



United Nations  
Educational, Scientific and  
Cultural Organization

# International Guidelines on Sexuality Education:

**An evidence informed approach to effective sex,  
relationships and HIV/STI education**

**Conference Ready Version**

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**An evidence informed approach to effective sex,  
relationships and HIV/STI education**

A decorative graphic consisting of three wavy lines. The top line is dotted, the middle line is solid orange, and the bottom line is solid dark grey. They all follow a similar undulating path across the page.

**June 2009**

**Conference Ready Version**

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Published by UNESCO

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Composed and printed by UNESCO  
ED-2009/WS/36 (CLD 1983.9)

**Conference Ready Version**

# Acknowledgements

These *International Guidelines on Sexuality Education* were commissioned by Chris Castle and Ekua Yankah in the Section on HIV and AIDS, Division for the Coordination of United Nations (UN) Priorities in Education at the United Nations Educational, Scientific and Cultural Organization (UNESCO) with support from Laura Laski and Prateek Awasthi in the Adolescent and Youth Cluster of the Reproductive Health Branch at the United Nations Population Fund (UNFPA).

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UNESCO and UNFPA would like to thank the William and Flora Hewlett Foundation for hosting the global technical consultation that contributed to the development of the guidelines. The organizers would also like to express their gratitude to all of those who participated in the consultation, which took place from 18-19 February 2009 in Menlo Park, USA (in alphabetical order):

Prateek Awasthi, UNFPA; Arvin Bhana, Human Sciences Research Council South Africa; Chris Castle, UNESCO; Dhianaraj Chetty, ActionAid; Esther Corona, Mexican Association for Sex Education and World Association for Sexual Health; Mary Guinn Delaney, UNESCO; Nanette Ecker, SIECUS; Nike Esiet, Action Health, Inc. (AHI); Peter Gordon, independent consultant; Christopher Graham, Ministry of Education, Jamaica; Nicole Haberland, Population Council/USA; Douglas Kirby, ETR Associates; Sam Kalibala, Population Council/Kenya; Wenli Liu, Beijing Normal University; Elliot Marseille, Health Strategies International; Helen Omondi Mondoh, Egerton University; Prabha Nagaraja,

Talking about Reproductive and Sexual Health Issues (TARSHI); Hans Olsson, The Swedish Association for Sexuality Education; Grace Osakue, Girls' Power Initiative (GPI) Edo State, Nigeria; Jo Reinders, World Population Fund (WPF); Sara Seims, the William and Flora Hewlett Foundation; Ekua Yankah, UNESCO

Written comments and contributions were also gratefully received from (in alphabetical order):

Vicky Anning, independent consultant; Prateek Awasthi, UNFPA; Andrew Ball, World Health Organization (WHO); Tanya Baker, Youth Coalition for Sexual and Reproductive Rights; Jeffrey Buchanan, UNESCO; Chris Castle, UNESCO; Katie Chau, Youth Coalition for Sexual and Reproductive Rights; Judith Cornell, UNESCO; Anton De Grauwe, UNESCO International Institute for Educational Planning (IIEP); Jan De Lind Van Wijngaarden, UNESCO; Marta Encinas-Martin, UNESCO; Jane Ferguson, WHO; Dakmara Georgescu, UNESCO International Bureau of Education (IBE); Anna Maria Hoffmann, United Nations Children's Fund (UNICEF); Roger Ingham, University of Southampton; Laura Laski, UNFPA; Changu Mannathoko, UNICEF; Rafael Mazin, Pan-American Health Organization (PAHO); Maria Eugenia Miranda, Youth Coalition for Sexual and Reproductive Rights; Jenny Renju, Liverpool School of Tropical Medicine & National Institute for Medical Research, United Republic of Tanzania; Mark Richmond, UNESCO; Justine Sass, UNESCO; Barbara Tournier, UNESCO IIEP; Friedl Van den Bossche, UNESCO; Diane Widdus, UNICEF; Arne Willems, UNESCO; Ekua Yankah, UNESCO.

UNESCO would like to acknowledge Sandrine Bonnet, UNESCO IBE; Claire Cazeneuve, UNESCO IBE; Claire Greslé-Favier, WHO; Magali Moreira, UNESCO IBE and Lynne Sergeant, UNESCO IIEP for their contributions to the bibliography of useful resources.

# Acronyms

<b>ASRH</b>	Adolescent sexual and reproductive health
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Anti-retroviral Therapy
<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination against Women
<b>CRC</b>	Convention on the Rights of the Child
<b>EFA</b>	Education for All
<b>ETR</b>	Education, Training and Research
<b>FHI</b>	Family Health International
<b>HFLE</b>	Health and Family Life Education
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPV</b>	Human Papilloma Virus
<b>IATT</b>	Inter-Agency Task Team
<b>IBE</b>	International Bureau of Education (UNESCO)
<b>ICPD</b>	International Conference on Population and Development
<b>IIEP</b>	International Institute for Educational Planning (UNESCO)
<b>IPPF</b>	International Planned Parenthood Federation
<b>LGBTQ</b>	Lesbian, Gay, Bisexual, Transgender, Questioning
<b>MDG</b>	Millennium Development Goal
<b>MoE</b>	Ministry of Education
<b>MoH</b>	Ministry of Health
<b>NGO</b>	Non-Governmental Organization
<b>PEP</b>	Post-exposure prophylaxis
<b>SIECUS</b>	Sexuality Information and Education Council of the United States
<b>SRE</b>	Sex and relationships education
<b>SRH</b>	Sexual and reproductive health
<b>SRHR</b>	Sexual and reproductive health and rights
<b>STD</b>	Sexually transmitted disease
<b>STI</b>	Sexually transmitted infection
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>VCT</b>	Voluntary Counselling and Testing
<b>WHO</b>	World Health Organization

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# **Part 1:**

## **The rationale for sexuality education**

# 1. Introduction

## 1.1 What is sexuality education and why is it important?

This document is based upon the following assumptions:

- Sexuality is a fundamental aspect of human life: it has physical, psychological, spiritual, social, economic, political and cultural dimensions.
- Sexuality cannot be understood without reference to gender.
- Diversity is a fundamental characteristic of sexuality.
- The rules that govern sexual behaviour differ widely across and within cultures. Certain behaviours are seen as acceptable and desirable while others are considered unacceptable. This does not mean that these behaviours do not occur, or that they should be excluded from discussion within the context of sexuality education.

Few young people receive adequate preparation for their sexual lives. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs), including HIV. Many young people approach adulthood faced with conflicting and confusing messages about sexuality and gender. This is often exacerbated by embarrassment, silence, and disapproval of open discussion of sexual matters by adults, including parents and teachers, at the very time when it is most needed. Globally, young people are becoming sexually mature and active at an earlier age. They are also marrying later, thereby extending the period of time from sexual debut until marriage.

It is therefore essential to recognise the need and entitlement of *all* young people to sexuality education. Some young people are more vulnerable than others, particularly those with disabilities and those living with HIV.

Effective sexuality education can provide young people with age-appropriate, culturally relevant and

scientifically accurate information. It includes structured opportunities for young people to explore their attitudes and values, and to practise the skills they will need to be able to make informed decisions about their sexual lives.

Effective sexuality education is a critical part of HIV prevention and is also critical to achieving Universal Access<sup>1</sup> targets for prevention, treatment, care and support. While there are no programmes that can eliminate the risk of HIV and other STIs, unintended pregnancy, and coercive or abusive sexual activity, properly designed and implemented programmes can reduce some of these risks.

Studies show (see section 4) that effective programmes can:

- reduce misinformation;
- increase knowledge;
- clarify and solidify positive values and attitudes;
- increase skills;
- improve perceptions about peer group norms; and
- increase communication with parents or other trusted adults.

Research shows that programmes sharing certain key characteristics can help to:

- delay the debut of sexual intercourse;
- reduce the frequency of unprotected sexual activity;
- reduce the number of sexual partners; and
- increase the use of protection against pregnancy and STIs during sexual intercourse.

School settings provide an important opportunity to reach large numbers of young people with sexuality education before they become sexually active, as well as offering an appropriate structure (i.e. the formal curriculum) within which to do so.



## 1.2 What are the goals of sexuality education?

The primary goal of sexuality education is that children and young people are equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV and AIDS.

Sexuality education programmes usually have several mutually reinforcing objectives:

- to increase knowledge and understanding;
- to explain and clarify feelings, values and attitudes;
- to develop or strengthen skills; and
- to promote and sustain risk-reducing behaviour.

In a context where ignorance and misinformation can be life-threatening, sexuality education is part of the duty of care of education and health authorities and institutions. In its simplest interpretation, teachers in the classroom have a responsibility to act in the place of parents, contributing towards ensuring the protection and well-being of children and young people. At another level, the *International Guidelines* call for political and social leadership from education and health authorities to respond to the challenge of giving children and young people access to the knowledge and skills they need in their personal, social and sexual lives.

When it comes to sexuality education, programme designers, researchers and practitioners sometimes differ in the relative importance they attach to each objective and to the overall intended goal and focus. For educationalists, sexuality education is a broader activity in which increasing knowledge (e.g. about HIV) is valued both as a worthwhile outcome in its own right, as well as being a first step towards adopting safer behaviour. For public health professionals, the conceptual emphasis would be on reducing sexual risk behaviour. In these *International Guidelines*, sexuality education combines a rights-based approach with the best available evidence and encompasses a broad range of topics and concepts that may or may not include behaviourally defined outcomes.

Different kinds of evidence exist in relation to sexuality education: practitioner experience and expert opinion, for example, about 'promising approaches'; as well as the conventional standards of published research studies. While section four on the evidence base of sexuality education is drawn primarily from published research studies, the *International Guidelines* are also deliberately informed by practitioner experience and expert opinion.

## 1.3 What are the purpose and intended audience of the *International Guidelines*?

These *International Guidelines* have been developed primarily to assist education, health and other relevant authorities in the development and implementation of school-based sexuality education programmes and materials. It does this primarily by recommending a set of age-specific standard learning objectives for sexuality education.

The *International Guidelines* will have immediate relevance for education ministers and their professional staff, including curriculum developers, school principals and teachers. However, anyone involved in the design, delivery and evaluation of sexuality education, in and out of school, may find this document useful. Emphasis is placed on the need for programmes that are logically designed, that address factors such as beliefs, values and skills that are amenable to change and which, in turn, may affect sexual behaviour.

The *International Guidelines* are a framework for offering guided access to information and knowledge to children and young people about sex, relationships and HIV/STIs within a structured teaching/learning process. They are intended to:

- Promote an understanding of the need for sexuality education programmes by raising awareness of salient sexual and reproductive health issues and concerns affecting children and young people;
- Provide a clear understanding of what sexuality education comprises, what it is intended to do, and what the possible outcomes are;
- Provide guidance to education authorities on how to build support at community and school level for sexuality education;
- Build teacher preparedness and enhance institutional capacity to provide good quality sexuality education; and
- Provide guidance on how to develop responsive, culturally-relevant and age-appropriate sexuality education materials and programmes.

This document is not a curriculum. Instead, it focuses on the ‘why’ and ‘what’ issues that require attention in strategies to introduce or strengthen sexuality education. The ‘how to’ issues are dealt with in classroom resources, curricula and materials for training teachers that already exist. A list of recommended resources can be found in Appendix VI.

The *International Guidelines* are based upon approaches to sexuality education that are rights-based, culturally sensitive, respectful of sexual and gender diversity, comprehensive, scientifically accurate, age-appropriate and evidence-based. They are intended to address the diverse realities and needs of young people’s lives across a wide range of settings. The *International Guidelines* are thus intended to be a global template, on the basis of which regional and country adaptations can be made in order to increase local relevance and acceptance.

In a broader context, sexuality education is an essential part of a good curriculum and, it could also be argued, it is an essential part of a comprehensive response to HIV and AIDS at the national level.

## 1.4 How are the *International Guidelines* structured?

The *International Guidelines* are divided into three parts. The first part explains what sexuality education is and why it is important. It sets out a clear overview of the available evidence in relation to the impact of sexuality education and presents the key characteristics of effective programmes. The second part of the *International Guidelines* presents a global template of key concepts and topics, together with learning objectives for four distinct age groups. They establish a set of benchmarks with which to monitor the content of what is being taught and to assess progress towards the achievement of teaching and learning objectives. The third section provides the reader with detailed background information on the evidence base described in Part I, together with other relevant and practical resource material.

Thus, the *International Guidelines* provide a platform for those involved in policy, advocacy and the development of new programmes or the review and scaling up of existing programmes.

## 1.5 How were the *International Guidelines* developed?

The development of the *rationale* was informed by a specially commissioned systematic review of the literature on the impact of sexuality education on sexual behaviour. The review considered 87 studies from around the world; 29 studies were from developing countries, 47 from the United States and 11 from other developed countries. Furthermore, common characteristics of existing and evaluated sexuality education programmes were outlined that have been found to be effective in terms of increasing knowledge, clarifying values and attitudes, increasing skills and at times impacting upon behaviour. These characteristics were identified and verified through independent review.

The development of the *topics and learning objectives* was informed by a specially commissioned review of existing curricula, guidelines and standards as identified by key informants and through searches of relevant databases, websites and list serves<sup>2</sup> (see Appendix V). The review yielded a diverse sample of widely used, and in some cases rigorously evaluated, sexuality education curricula across a range of settings and audiences, both in-school and out of school. Thus, while by no means exhaustive, the topics and learning objectives within these *International Guidelines* are drawn from a wide range of resources.

Curricula from 12 countries<sup>3</sup> were examined in order to identify common topics and related learning objectives. In addition, the *Guidelines for Comprehensive Sexuality Education*, developed by the Sexuality Information and Education Council of the United States (SIECUS), an international non-governmental organization (NGO), which draws on experience from India, Jamaica, Nigeria and the United States were consulted. The SIECUS Guidelines provide the overall organizing framework for the topics and learning objectives.

The topics and learning objectives in these *International Guidelines* have been selected on the basis of their inclusion within positively evaluated curricula, as well as relying on professional guidance from experts in the field. Thus, while the *International Guidelines* draw from educational and behaviour change theory, they

are solidly embedded in practical experience. Future versions of the *International Guidelines* will be produced and will incorporate feedback from their users around the world, and will continue to be based on the best available evidence.

These *International Guidelines* on sexuality education were further developed through key informant interviews with recognised experts (see list in Appendix V), and through a global technical consultation meeting held in February 2009 with experts from 13 different countries. The United Nations Population Fund (UNFPA) advisory group of young people and colleagues from UNESCO, UNICEF, UNFPA and WHO have also provided input for this document.

Decision-makers concerned with setting policy in education and other institutions providing for young people will be sensitive to the legal standing of these *International Guidelines* in the international community. In terms of process, they were developed by contracting and consulting with leading experts in the field of sexuality education and with the support and engagement of other UNAIDS Cosponsors. This is a recognised and legitimate protocol which ensures the highest quality safeguards, acceptability and ownership at international level. At the same time, it should be noted that the *International Guidelines* are voluntary and non-binding in character and do not have the force of an international normative instrument. Even for an average school setting this is important; teachers and school managers are called upon to balance the rights of parents and the rights of children and young people in areas of the curriculum which parents and communities consider to be sensitive. It is hoped that these *International Guidelines* constructively contribute to this effort.

## 2. Background

### 2.1 Young people's sexual and reproductive health

Sexual and reproductive ill-health are among the most important contributors to the burden of disease among young people. Ensuring the sexual and reproductive health of young people makes social and economic sense: HIV infection, other STIs, (unsafe) abortion and unintended pregnancy all place substantial burdens on families and communities and upon scarce government resources and yet such burdens are preventable and reducible. Promoting young people's sexual and reproductive health, including the provision of sexuality education in schools, is thus a key strategy towards achieving the Millennium Development Goals (MDGs), especially MDG 3 (achieving gender parity), MDG 5 (reducing maternal mortality) and MDG 6 (combating HIV and AIDS).

The sexual development of a person is a process that comprises physical, psychological, emotional, social and cultural dimensions. It is also inextricably linked to the development of one's gender identity and it unfolds within specific socio-economic and cultural contexts. The transmission of cultural values from one generation to the next forms a critical part of socialisation; it includes values related to gender and sexuality. In many communities, young people are exposed to several sources of information and values (e.g. from parents, teachers, media and peers). These often present them with alternative or even conflicting values about gender and sexuality. Furthermore, parents are often reluctant to engage in discussion of sexual matters with children because of cultural norms, their own ignorance or discomfort.

According to the World Health Organization (WHO, 2002), in many cultures puberty represents a time of social as well as physical change for both boys and girls. For boys, puberty can be a gateway to increased freedom, mobility and social opportunities. For girls, puberty may signal an end to schooling and mobility, and the beginning of adult life, with marriage and childbearing as expected possibilities in the near future.

'Being sexual' is an important part of many people's lives: it can be a source of pleasure and comfort and a way of expressing affection and love. Whether or not young people choose to be sexually active, comprehensive sexuality education prioritises the acquisition and/or reinforcement of values such as reciprocity, equality and respect that are prerequisites for healthier and safer sexual and social relationships. Abstinence is only one of a range of choices available to young people and programmatic interventions need to be assessed carefully in relation to the evidence base for sexuality education.

The past four decades have seen dramatic changes in our understanding of human sexuality and sexual behaviour<sup>4</sup>. The global HIV epidemic has played a role in bringing about this change, because it was rapidly understood that, in order to address HIV – which is largely sexually transmitted – we needed to acquire a better understanding of gender and sexuality. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2008), more than ten million young people globally are living with HIV, two-thirds of whom live in sub-Saharan Africa. New HIV infections are concentrated among young people, with roughly 45 per cent of all new infections occurring among those aged 15 to 24 years. Globally, women constitute 50 per cent of the total number of people living with HIV, but in sub-Saharan Africa, this proportion rises to approximately 61 per cent<sup>5</sup>.

### Box 1. Involving Young People

A report published in 2007 by the UK Youth Parliament, based on questionnaire responses from over 20,000 young people, says that 40 per cent of young people described the Sex and Relationships Education (SRE) they had received as either 'poor' or 'very poor' with a further 33 per cent describing it as only average. Other key findings from the survey were that:

- 43 per cent of respondents reported not having been taught anything about relationships;
- 55 per cent of the 12-15 year olds and 57 per cent of the 16-17 year old females reported not having been taught how to use a condom;
- Just over half of respondents had not been told where their local sexual health service was located.

Involving a structure like the Youth Parliament in the process of reviewing SRE provision yielded important data. The data also shows the scale of the challenge in meeting young people's needs, even in developed countries' education systems.

Source: Fisher, J. and McTaggart J. *Review of Sex and Relationships Education (SRE) in Schools*, Issues 2008, Chapter 3, Section 14. [www.teachernet.gov.uk/\\_doc/13030/SRE%20final.pdf](http://www.teachernet.gov.uk/_doc/13030/SRE%20final.pdf) or <http://ukyouthparliament.org.uk/sre>

In many countries, young people with HIV are living longer, thanks to improved access to treatment with anti-retroviral therapy (ART) and related medical and psychosocial support. Young people living with HIV have particular needs in relation to their sexual and reproductive health, including: opportunities to discuss living positively with HIV; sexuality and relationships; and issues relating to disclosure, stigma and discrimination. However, these needs are often unmet. For example, experience in Uganda<sup>6</sup> reveals that young people living with HIV are often discriminated against by sexual and reproductive health services and are actively discouraged from becoming sexually active. Sixty per cent of those living with HIV reported that they had not disclosed their status to their sexual partners; 39 per cent were in relationships with a sexual partner who did not have HIV. Many did not know how to disclose their status to their partners.

Knowledge about HIV transmission remains low in many countries, with women generally less well informed than men. According to UNAIDS (2006), many young people still lack accurate, complete information on how to avoid exposure to HIV. While UNAIDS reports that more than 70 per cent of young men know that condoms can protect against HIV, only 55 per cent of young women cite condoms as an effective strategy for HIV prevention. Survey data from sixty-four countries indicate that only 40 per cent of males and 38 per cent of females aged 15 to 24 had accurate and comprehensive knowledge about HIV and its prevention<sup>7</sup>. UNAIDS (2007) reported that at least half of students around the world did not receive any school-based HIV education. Furthermore, five of fifteen countries reporting to UNAIDS in 2006 indicated the coverage of HIV prevention in schools was less than 15 per cent. This figure falls well short of the global goal of 'ensuring comprehensive HIV knowledge in 95 per cent of young people by 2010' (UN, 2001).

Globally, young people continue to have high rates of STIs. According to the International Planned Parenthood Federation (IPPF, 2006), each year at least 111 million new cases of curable STIs occur among young people aged between 10 and 24, and up to 4.4 million girls aged 15 to 19 years seek abortions, the majority of which will be unsafe. Ten per cent of births worldwide are to teenage mothers, who experience higher rates of maternal mortality than older women.

## 2.2 The role of schools

In the larger context, the education sector has a critical role to play in preparing children and young people for their adult roles and responsibilities<sup>8</sup>. The transition to adulthood requires being informed and equipped with the appropriate skills and knowledge to make responsible choices in our social and sexual lives. In most countries, young people between the ages of five and thirteen spend relatively large amounts of time in school. Thus, schools provide a practical means of reaching large numbers of young people from diverse social backgrounds in ways that are replicable and sustainable<sup>9</sup>. Teachers are likely to be the most skilled and trusted source of information. Evidence from UNESCO, WHO, the UNICEF and the World Bank point to a core set of cost-effective activities that can contribute to making schools healthy for children<sup>10</sup>.

Moreover, in many countries, young people have their first sexual experiences while they are still attending school, making the setting even more important as an opportunity to provide education about sexual and reproductive health. In many communities, schools are also social support centres, trusted institutions that can link children, parents, families and communities with other services (for example, health services). Thus, they have the potential to promote communication about important issues between young people, trusted adults and the broader community.

## 2.3 Young people's needs and entitlement to sexuality education

Young people want and need sexual and reproductive health information (Biddlecom, 2007). Some organizations now promote sexual and reproductive health education as a right and argue that this is supported by specific conventions (see Appendix II). For example, the Center for Reproductive Rights (2008) argues that international human rights standards, as articulated by UN governing bodies and other international organizations, require that governments guarantee the rights of young people

to health, life, education and non-discrimination, by making comprehensive sexuality education that is scientifically accurate, objective and free from prejudice and discrimination available to them in primary and secondary schools.

In these *International Guidelines* the need for sexuality education is interpreted from the standpoint that children and young people have a specific need for information and skills on sexuality education that makes a difference to their life chances. The threat to life and their well-being exists in a range of contexts, whether it is in the form of abusive relationships, exposure to HIV or stigma and discrimination because of their sexual orientation. Given the complexity of the task facing any teacher or parent in guiding and supporting the process of learning and growth, it is crucial to strike the right balance between the need to know and what is age appropriate and relevant.

## 2.4 Addressing sensitive issues

The challenge for sexuality education is to reach young people before they become sexually active, whether this is through choice, necessity (e.g. in exchange for money, food or shelter) or coercion. Some students, now or in the future, will be sexually active with members of their own sex. These are sensitive and challenging issues for those with responsibility for designing and delivering sexuality education. Overlooking same-sex relationships is not a solution.

Furthermore, in countries with low HIV prevalence, the needs of those who may be most vulnerable must be taken into consideration in sexuality education programmes. For many developing countries, this discussion will require attention to other aspects of vulnerability, particularly poverty, disability and socio-economic factors.

These *International Guidelines* emphasise the importance of addressing the *reality* of young people's sexual lives: this includes those aspects of which policy-makers and others may personally disapprove. Decision-makers with a duty of care have to recognise that good scientific evidence and public health imperatives should take priority over personal opinion.



### 3. Building support for sexuality education

Despite the clear and pressing need for effective school-based sexuality education, in most countries throughout the world this is still not available. There are many reasons for this, including ‘perceived’ or ‘anticipated’ resistance resulting from misunderstandings about the nature, purpose and effects of sexuality education. Evidence suggests that many people, including education ministry staff, school principals and teachers, may not be convinced of the need to provide sexuality education, or else are reluctant to provide it because they lack the confidence and skills to do so. Teachers’ personal or professional values could also be in conflict with the issues they are being asked to address, or else there is no clear guidance about what to teach and how to teach it (see Table 1, which provides some typical examples of concerns that are expressed about introducing or promoting sexuality education).

**Table 1. Common concerns about the provision of sexuality education**

Concerns	Response
<b>Sexuality education leads to early sex.</b>	Research from around the world clearly indicates that, rather than leading to early sexual initiation, sexuality education leads to later and more responsible sexual behaviour.
<b>Sexuality education deprives children of their ‘innocence’.</b>	Getting the right information that is scientifically accurate, non-judgemental, age-appropriate and complete, at an early age, is something to which all children and young people are entitled. In the absence of this, children and young people will often receive conflicting and sometimes damaging messages from their peers, the media or other sources. Good quality sexuality education balances this through the provision of correct information and an emphasis on values.
<b>Sexuality education is against our culture or religion.</b>	The International Guidelines are built upon the principle of being culturally relevant as well as engaging and building support among the custodians of culture in a given community. Key stakeholders, including religious leaders, must be involved in the development of what form sexuality education takes. At the same time, respect for culture and values has to be balanced with the needs of young people, especially girls and young women.
<b>It is the role of parents and the extended family to educate our young people about sexuality.</b>	Traditional mechanisms for preparing young people for sexual life and relationships may be breaking down in some places, often with nothing left in their place. Sexuality education recognises the primary role of parents and the family as a source of information, support and care in shaping a healthy approach to sexuality and relationships. Government’s role, through ministries of education, schools and teachers, is to provide a safe and supportive learning environment and the tools and materials for good quality sexuality education.
<b>Parents will object to sexuality education being taught in schools.</b>	Schools and education institutions where children and young people spend a large part of their lives are an appropriate environment for young people to learn about sex, relationships and HIV/STIs. When these institutions function well, young people are able to develop the values, skills and knowledge to make informed and responsible choices in their social and sexual lives. Furthermore, teachers remain the best qualified and the most trusted providers of information and support for most children and young people.
<b>Sexuality education may be good for young people, but not for young children.</b>	These International Guidelines are built upon the principle of age-appropriateness reflected in the grouping of learning objectives. Sexuality education encompasses a range of relationships, not only sexual relationships. Children are aware of and recognise these relationships long before they act on their sexuality and therefore need the skills to understand their bodies, relationships and feelings from an early age. Sexuality education lays the foundations – e.g. learning correct names for parts of the body, understanding principles of human reproduction, exploring family and interpersonal relationships and learning concepts such as safety and confidence. These can then be built upon gradually, in line with the age and development of a child.
<b>Teachers may be willing to teach sexuality education but are uncomfortable, lacking in skill or afraid to do so.</b>	Well-trained, supported and motivated teachers are an essential part of the delivery of good quality sexuality education. Clear sectoral and school policies and curricula help to support teachers in the delivery of sexuality education in the classroom. Teachers should be encouraged to specialise in sexuality education through added emphasis on formalising the subject in the curriculum, as well as stronger professional development and support.
<b>Sexuality education is already covered in other subjects (biology, life skills or civics education).</b>	Ministries, schools and teachers in many countries are already responding to the challenge of improving sexuality education. Whilst recognising the value of these efforts, using these International Guidelines presents an opportunity to evaluate and strengthen the curriculum, teaching practice and the evidence base in a dynamic and rapidly changing field.
<b>Sexuality education should promote values.</b>	These International Guidelines on sexuality education support a rights-based approach in which values are inextricably linked to universally accepted human rights.

Facilitating dialogue between different stakeholders, especially between young people and adults, could be considered as one of the strategies to build support. In many cases, especially around such sensitive issues, the voices of young people are rarely heard and understood.

### 3.1 Key stakeholders

Opposition to sexuality education is not inevitable. Should opposition occur, it is by no means insurmountable. Ministries of education have to play a critical role in building consensus on the need for sexuality education through consultation and advocacy with key stakeholders, including, for example:

- Young people and organizations that work with them (including youth parliaments);
- Policy-makers and politicians;
- Government ministries, including health and others concerned with the needs of young people;
- Education professionals and institutions including teachers, head teachers and training institutions;
- Teachers' trade unions;
- Parent-teacher associations;
- Religious leaders and/or faith-based organizations;
- Researchers;
- Local communities and their representatives;
- Lesbian, gay, bisexual and transgender groups;
- NGOs, particularly those working on sexual and reproductive health with young people;
- Media (local and national);
- Training institutions for health professions; and
- Donors.

Young people need to be involved in the development and design of programmes to ensure that these are youth-friendly, gender-sensitive, rights-based, and that they reflect the reality of their lives. Sexuality education is important for all children and young people, in and out of school. While these *International Guidelines* focus specifically upon the school setting, much of the content will be equally relevant to those children who are out of school.

### 3.2 Developing the case for sexuality education

A clear rationale for the introduction of sexuality education can be developed on the basis of evidence from the local/national situation and needs assessments. This should include local data on HIV, other STIs and teenage pregnancy, sexual behaviour patterns of young people, including those thought to be most vulnerable, together with studies on specific factors associated with HIV/STI risk and vulnerability. Ideally, this will include both quantitative and qualitative, sex and gender-specific data regarding the age of sexual initiation, partnership dynamics including the number of sexual partners, age differences, coercion, duration and concurrency, as well as use of condoms and contraception.

#### Box 2. Latin America: Leading the call to action

A growing number of governments around the world are confirming their commitment to sexuality education as a priority essential to achieving national development, health and education goals. In August 2008, health and education ministers from across Latin America and the Caribbean came together in Mexico City to sign a historic declaration affirming a mandate for national school-based sexuality and HIV education throughout the region. The declaration advocates for strengthening comprehensive sexuality education and to make it a core area of instruction at both primary and secondary schools in the region.

Main features of the Ministerial Declaration:

- Implement and/or strengthen multisectoral strategies of comprehensive sexuality education and promotion and care of sexual health, including HIV prevention;
- Comprehensive sexuality education entails human rights, ethical, biological, emotional, social, cultural and gender aspects; respects diversity of sexual orientations and identities.

See also: [http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080731\\_Leaders\\_Ministerial.asp](http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080731_Leaders_Ministerial.asp)  
[http://data.unaids.org/pub/BaseDocument/2008/20080801\\_minsterdeclaration\\_en.pdf](http://data.unaids.org/pub/BaseDocument/2008/20080801_minsterdeclaration_en.pdf)  
[http://data.unaids.org/pub/BaseDocument/2008/20080801\\_minsterdeclaration\\_es.pdf](http://data.unaids.org/pub/BaseDocument/2008/20080801_minsterdeclaration_es.pdf)

### 3.3 Planning for implementation

In some countries, National Advisory Councils and/or Task Force Committees have been established by ministries of education to inform the development of relevant policies, to generate support for programmes, and to assist in the development and implementation of sexuality education programmes. Council and committee members have included young people, national experts and practitioners in sexual and reproductive health, rights, education, gender, youth development and education. Individually and collectively, council and committee members can participate in sensitisation and advocacy, review draft materials and policies, and develop a comprehensive workplan for classroom delivery together with plans for monitoring and evaluation. At the policy level, a well-developed national policy on sexuality education should be explicitly linked to education sector plans, as well as to the national strategic plan and policy framework on HIV and AIDS. These should clearly promote confidentiality and prohibit sexual harassment and abuse among school personnel (including teachers) and discrimination in general (amongst students and teachers).

In order to ensure continuity and consistency and to minimise opposition to improving sexuality education, discussions about building support and capacity for school-based sexuality education need to occur at, and across, all levels. Participants in such discussions should be provided, as appropriate, with orientation and training in sexuality and sexual and reproductive health. This should include values clarification and desensitisation. Teachers responsible for the delivery of sexuality education will usually also need desensitisation and training in the use of active, participatory learning methods.

### 3.4 At school level

The overall school context within which sexuality education is to be delivered is crucially important. In this regard, two linked factors will make a difference: (1) leadership, and (2) policy guidance. Firstly, school management is expected to take the lead in motivating and supporting, as well as creating the right climate in which to implement sexuality education and address the needs of young people. From the perspective of a classroom, instructional leadership requires teachers to take the lead in how children and young people experience sexuality education through discovery, learning and growth. In a climate of uncertainty or conflict, the capacity to lead amongst managers and teachers can make the difference between successful programmatic interventions and those that falter.

Secondly, implementing sexuality education within the framework of a clear set of relevant school-wide policies or guidelines concerning, for example, sexual and reproductive health, gender discrimination (including sexual harassment) and bullying (including homophobia) has a number of advantages. A policy framework will:

- Provide an institutional framework for the implementation of sexuality education programmes;
- Anticipate and address sensitivities concerning the implementation of sexuality education programmes;
- Set standards on confidentiality;
- Set standards of appropriate behaviour; and
- Protect and support teachers responsible for delivery of sexuality education and, if appropriate, protect or increase their status within the school and community.

It is possible that some of these issues may be well defined through pre-existing school policies. For example, most school-based policies on HIV and AIDS pay specific attention to issues of confidentiality, discrimination and gender inequality. However, in the absence of pre-existing guidance, a policy on sexuality education will clarify and strengthen the school's commitment to:

- Curriculum delivery by trained teachers;
- Parental involvement;
- Procedures for responding to parental concerns;
- Supporting pregnant learners to continue with their education;



- Making the school a health-promoting environment (through provision of clean, private, separate toilets for girls and boys, and other measures);
- Action in the case of infringement of policy, for example, in the case of breach of confidentiality, stigma and discrimination, sexual harassment or bullying; and
- Promoting access and links to local sexual and reproductive health and other services.

Decisions will also need to be made about how to select teachers to implement sexuality education programmes, and whether this should be done by aptitude or personal preference, or whether it should be required of all teachers delivering a particular subject or set of subjects.

Implementation planning needs to take into consideration adequate development and provision of resources (including materials), and needs to reach agreement on the place of the programme within the broader curriculum. Furthermore, it should include planning for pre-service training at teacher training colleges, and in-service and refresher training for classroom teachers, to build their comfort and confidence, and to develop their skills in participatory and active learning.

### 3.5 Parental involvement

Many parents may have strong views and concerns (sometimes misplaced) about the effects of sexuality education. The cooperation and support of parents should be sought from the outset and regularly reinforced. It is important to emphasise the shared primary concern of schools and parents with promoting the safety and well-being of students. Parental concerns can be addressed through the provision of parallel programmes that orient them to the content of their children's learning and that equip them with skills to communicate more openly and honestly about sexuality with their children, putting their fears to rest and supporting the school's efforts in delivering good quality sexuality education. If parents themselves are anxious about the appropriateness of curriculum content or unwilling to engage in what their children learn through sexuality education programmes, the chances of personal growth for children and young people are likely to be limited. However, in the best possible scenario, teachers and parents work to support each other in implementing a guided and structured teaching/learning process.

### 3.6 Schools as community resources

Schools can become trusted community centres that provide necessary links to other resources, such as services for sexual and reproductive health, substance abuse, gender-based violence and domestic crisis<sup>11</sup>. This link between the school and community is particularly important in terms of child protection, since some groups of children and young people are particularly vulnerable. These include those who are displaced, disabled, orphaned, or living with HIV. They need relevant information and skills to protect themselves, together with access to community services to help protect them from violence, exploitation and abuse.

## 4. The evidence base for sexuality education

### 4.1 2008 Review of the impact of sexuality education on sexual behaviour

This section presents a summary of the findings of a recent review of the impact of sexuality education on sexual behaviour. It was commissioned by UNESCO in 2008 as part of the development of these International Guidelines. The review considered 87 studies from around the world (see Table 2 below); 29 studies were from developing countries, 47 from the United States and 11 from other developed countries (please refer to Appendix IV for a detailed description of the criteria for the selection of evaluation studies). All of the programmes were designed to reduce unintended pregnancy or STIs, including HIV; they were not designed to address the varied needs of young people or their right to information about many topics. All were curriculum-based programmes, 70 per cent were implemented in schools and the remainder were implemented in community or clinic settings. Many were very modest, lasting less than 30 hours or even 15 hours. The review examined the impact of these programmes on those sexual behaviours that directly affect pregnancy and sexual transmission of HIV and other STIs. It did not review impact on other behaviours such as health-seeking behaviour, sexual harassment, sexual violence or unsafe abortion.

**Table 2. The number of sexuality education programmes with indicated effects on sexual behaviours**

	Developing Countries (N=29)	United States (N=47)	Other developed Countries (N=11)	All Countries (N=87)	
<b>Initiation of Sex</b>					
• Delayed initiation	6	15	2	23	38%
• Had no significant impact	16	17	7	37	62%
• Hastened initiation	0	0	0	0	0%
<b>Frequency of Sex</b>					
• Decreased frequency	4	6	0	10	31%
• Had no significant impact	5	15	1	21	66%
• Increased frequency	0	0	1	1	3%
<b>Number of Sexual Partners</b>					
• Decreased number	5	11	0	16	44%
• Had no significant impact	8	12	0	20	56%
• Increased number	0	0	0	0	0%
<b>Use of Condoms</b>					
• Increased use	7	14	2	23	40%
• Had no significant impact	14	17	4	35	60%
• Decreased use	0	0	0	0	0%
<b>Use of Contraception</b>					
• Increased use	1	4	1	6	40%
• Had no significant impact	3	4	1	8	53%
• Decreased use	0	1	0	1	7%
<b>Sexual Risk-Taking</b>					
• Reduced risk	1	15	0	16	53%
• Had no significant impact	3	9	1	13	43%
• Increased risk	1	0	0	1	3%

## Limitations and strengths of the review

There were a number of limitations to the studies and, by implication, to the review. Too few of the studies were conducted in developing countries. Some studies suffered from an inadequate description of their respective programmes. None examined programmes for gay or lesbian or other young people engaging in same-sex sexual behaviour. Some studies had only barely adequate evaluation designs and many were statistically underpowered. Most did not adjust for multiple tests of significance. Few studies measured impact upon either STI or pregnancy rates and fewer still measured impact on STI or pregnancy rates with biological markers. Finally, there were inherent biases that affect the publication of studies: researchers are more likely to try to publish articles if positive results support their theories. Also, programmes and journals are more likely to accept articles for publication when results are positive. Fortunately, some of these biases counteract each other.

Despite these limitations, there is much to be learned from these studies for several reasons: 1) 87, all with experimental or quasi-experimental designs, is a large number of studies; 2) some of the studies employed very strong research designs and their results were similar to those with weaker evaluation designs; 3) when the same programme was studied multiple times, often the same or similar results were obtained; and 4) the programmes that were effective at changing sexual behaviour often shared common characteristics.

## 4.2 Impact on sexual behaviour

Of sixty studies that measured the impact of sexuality education programmes upon the initiation of sexual intercourse, 38 per cent delayed the initiation of sexual intercourse among either the entire sample or an important sub-sample, while 62 per cent had no impact. Notably, none of the programmes hastened the initiation of sexual intercourse. Similarly, 31 per cent of the programmes led to a decrease in the frequency of sexual intercourse (which includes reverting to abstinence), while 66 per cent had no impact and 3 per cent increased the frequency of sexual intercourse. Finally, 44 per cent of the programmes decreased the number of sexual partners, 56 per cent had no impact in this regard, and none led to an increased number of partners. The small percentages of results in the undesired direction are

equal to, or less than, that which would be expected by chance, given the large number of tests of significance that were examined. Also by the same principle, a few of the positive results were probably the result of chance.

Thus, taken together, these studies provide very strong evidence that, despite fears to the contrary, programmes that emphasise not having sexual intercourse as the safest option and that also discuss condom and contraceptive use do not increase sexual behaviour. On the contrary:

- more than a third delayed the initiation of sexual intercourse;
- about a third decreased the frequency of sexual intercourse; and
- more than a third decreased the number of sexual partners, either among the entire sample or in important sub-samples.

## 4.3 Impact on condom and contraceptive use

Forty per cent of programmes were found to increase condom use, while sixty per cent had no impact and none decreased condom use. Forty per cent of programmes also increased contraceptive use; 53 per cent had no impact, and 7 per cent (a single programme) reduced contraceptive use. Some studies assessed measures that included both the amount of sexual activity as well as condom or contraceptive use in the same measure. For example, some studies measured the frequency of sexual intercourse without condoms or the number of sexual partners with whom condoms were not always used. These measures were grouped and labelled 'sexual risk-taking'. Fifty-three per cent of the programmes decreased sexual risk-taking; 43 per cent had no impact and three per cent were found to increase it.

In summary, these studies demonstrate that more than a third of the programmes increased condom or contraceptive use, while more than half reduced sexual risk-taking, either among entire samples or in important sub-samples.

The positive results on the three measures of sexual activity, namely on condom and contraceptive use and sexual risk-taking, are essentially the same when the studies are restricted to large studies with rigorous experimental designs. Thus, the evidence for the positive impacts upon behaviour is quite strong.

## 4.4 Impact on STI, pregnancy and birth rates

Because STI, pregnancy and childbearing occur less frequently than sexual activity, condom or contraceptive use, the distributions of the outcome measures of STI, pregnancy or childbearing require that considerably larger samples are needed to measure adequately the impact of programmes upon STI and pregnancy rates. Because many studies present results without having adequate statistical power, these results are not presented in Table 2.

While a small number of studies did evaluate programmes that had a significant reduction in STI and/or pregnancy rates, a greater number did not. At least two of the positive results were demonstrated by biological markers. However, other studies employing biological markers failed to demonstrate significant results, even when they had sufficient statistical power.

## 4.5 Magnitude and duration of impact

Even the effective programmes did not dramatically reduce risky sexual behaviour; their effects were more modest. The most effective programmes tended to lower risky sexual behaviour by, very roughly, one-fourth to one-third.

Some comprehensive programmes had effects on behaviour that lasted for as long as eight years afterwards, but most did not measure impact over such a long time span.

## 4.6 Breadth of behaviour results

Comprehensive programmes were effective in changing behaviour when implemented in school, clinic and community settings and when addressing different groups of young people: e.g. both males and females, sexually inexperienced and experienced youth, and young people at lower and higher risk in disadvantaged and better-off communities.

### Box 3. Mema Kwa Vijana (Good things for young people) <http://www.memakwavijana.org>

A particularly strong and interesting study is that of the Mema Kwa Vijana programme (MKV) in the United Republic of Tanzania. This study evaluated the impact of a multi-component programme comprised of a strong classroom-based curriculum, youth-friendly reproductive health services, community-based condom promotion and distribution for and by peers, together with a community sensitisation effort to create a supportive environment for the interventions.

A rigorous randomised trial found that the programme had some positive effects on reported sexual behaviour. For example, after a period of eight years the programme reduced the percentage of males who reported four or more lifetime sexual partners from 48 per cent to 40 per cent. It also increased the percentage of females who reported using a condom with a casual sexual partner from 31 per cent to 45 per cent.

However, the programme did not have any impact on HIV, other STI or pregnancy rates. There are at least three possible explanations for this. First, study participants' reports of sexual behaviour may have been biased and the programme may not have actually changed sexual behaviour. Second, the programme may have changed risk behaviours, but may not have changed the specific behaviours that have the greatest impact on pregnancy, STIs and HIV. Third, the programme may not have changed behaviours to such an extent as to make a difference in rates of pregnancy, STI and HIV.

Whatever the explanation, the study is a caution that even a well-designed, curriculum-based programme implemented in concert with mutually reinforcing community-based elements still may not have a significant impact on pregnancy, STI or HIV rates.

## 4.7 Results of replication studies

Results from several replication studies in the United States are encouraging<sup>12</sup>. These studies demonstrate that when programmes found to be effective at changing behaviour in one study were replicated in similar settings, either by the same or different researchers, they consistently yielded positive results. Programmes were less likely to remain effective when their duration was shortened considerably, when they omitted activities that focused on increasing condom use, or when they were designed for and evaluated in community settings, but were subsequently implemented in classroom settings.

## 4.8 Abstinence-only programmes

In addition to the effects of the sexuality education programs described above, eleven abstinence-only programmes, all of which were conducted in the United States<sup>13</sup>, met the selection criteria for the review. Six of the studies were particularly rigorous: employed experimental designs, measured long-term impact, and used statistical analyses. Results demonstrated that the curricula had no effects on initiation of sexual intercourse, age of initiation of sexual intercourse, abstinence in the previous twelve months, number of sexual partners, or condom use during sexual intercourse.

Studies of the remaining abstinence-only programmes were methodologically weaker. These employed quasi-experimental designs with comparison groups that were not always well-matched. Some had high attrition rates, weaker statistical analysis or measured programme impact for shorter periods of time. Of these five weaker studies, two reported that the evaluated programme

delayed sexual initiation. The three remaining studies showed no significant effect upon sexual behaviour. Two of these measured programme impact on the frequency of sexual intercourse among young people who had previously had sexual intercourse. Both reported that the programmes reduced the frequency of sexual intercourse. The single study that measured programme impact upon the number of sexual partners found that the curriculum resulted in a reduction in the number of sexual partners among participating young people. Of the studies with either experimental or quasi-experimental designs that measured impact on either condom or other contraceptive use, none found a significant effect.

## 4.9 Specific curriculum-based activities

Few studies have measured the impact of specific activities within curriculum-based programmes. Two studies considered the impact of particular activities within larger, more comprehensive HIV prevention programmes, integrated within multiple courses in schools. The first study found that, when young people observed a debate on whether schoolchildren should be taught how to use condoms and then wrote an essay about ways they could protect themselves from HIV, students were subsequently more likely to use condoms (Duflo *et al.*, 2006). The second study reported that the following all significantly decreased the rate of pregnancy among teenage girls to older men: providing HIV prevalence rates, disaggregated by age and sex; emphasising the risk of young women having sexual intercourse with older men (who are more likely to be HIV-positive); and showing a video about the danger of having sexual intercourse with older men (Dupas, 2007). This biological marker was perceived to be important both in itself and as an indicator of the amount of unprotected sexual intercourse between young women and older males.

## 4.10 Impact on cognitive factors

Nearly all sexuality education programmes that have been studied increased knowledge about different aspects of sexuality and risk of pregnancy or HIV/STIs. This is important, because increasing knowledge is a primary role of schools. Programmes that were designed to reduce sexual risk and employed a logic model also strove to change other factors that affect sexual behaviour. Those programmes that were effective at either delaying or reducing sexual activity or increasing condom or contraceptive use typically focused on:

- **Knowledge** e.g. of sexual issues, HIV, other STIs and pregnancy, including methods of prevention;
- **Perceptions of risk** e.g. of HIV, other STIs and of pregnancy;
- **Personal values** about sexual intercourse and abstinence;
- **Attitudes** about condoms and contraception;
- **Perceptions of peer norms** e.g. about sexual activity, condoms and contraception;
- **Self-efficacy** to refuse sexual intercourse and to use condoms;
- **Intention** to abstain from sexual intercourse or to restrict sexual activity or partners;
- **Communication** e.g. with parents or other adults and potentially with sexual partners.

It should be emphasised that some studies demonstrated that particular programmes improved these factors. Other studies have demonstrated that these factors, in turn, have an impact on adolescent sexual decision-making. Thus, there is considerable evidence that effective programmes actually changed behaviour by having an impact on these factors, which then positively affected young people's sexual behaviour.

## 4.11 Summary of results

- Curriculum-based programmes implemented in schools or communities should be viewed as an important component that can often (but not necessarily always) reduce sexual risk behaviour. However, isolated from broader programmes in the community, these programmes are sometimes insufficient to have a significant impact in terms of reducing HIV, STI or pregnancy rates.

- There is strong evidence that programmes did not have negative effects: in particular, they did not hasten or increase sexual behaviour. The studies also demonstrate that it is possible, with the same programmes, to delay sexual intercourse and to increase the use of condoms or other forms of contraception. In other words, a dual emphasis on abstinence together with use of protection for those who are sexually active is not confusing to young people. Rather, it can be both realistic and effective.
- Nearly all studies of sexuality education programmes demonstrate increased knowledge and about two-thirds of them demonstrate positive results on behaviour among either the entire sample or an important sub-sample.
- More than one-fourth of the studies improved two or more sexual behaviours among young people. Encouragingly, these studies with positive behavioural results include studies with strong research designs and replication studies with consistent results.
- Comparative analysis of effective and ineffective programmes provides strong evidence that programmes that incorporate key recommendations can be effective at changing the behaviours that put young people at risk of STIs and pregnancy.
- Even if sexuality education programmes improve knowledge, skills and intentions to avoid sexual risk or to use clinic services, reducing their risk may be challenging to young people if social norms do not support risk reduction or clinic services are not available.
- The sexuality education programmes studied had one big gap in common: none of them appeared to focus on the behaviours that cause by far the most HIV infections among adolescents in large parts of the world (i.e. Europe, Latin America and the Caribbean and Asia). Those behaviours are unsafe injecting drug use, unsafe sexual activity in the context of sex work and unprotected (mainly anal) sexual intercourse between men.



## 5. Characteristics of effective programmes

This section sets out the common characteristics of evaluated sexuality education programmes that have been found to be effective in terms of increasing knowledge, clarifying values and attitudes, and increasing skills and impacting upon behaviour<sup>14</sup> (see Tables 3a and 3b). These characteristics build upon those identified and verified through independent review<sup>15</sup>.

### 1. Implement programmes in schools and other youth-oriented organizations that reach large numbers of young people.

Programmes have been found to be effective in school, clinic and community settings. However, a majority of the programmes that had long-term positive effects on behaviour have been implemented in schools, or at least included an important curriculum component that was implemented in schools. Moreover, in many places, schools are the easiest place to reach large numbers of young people, especially younger children who are more likely to be in school.

### 2. Implement programmes that include at least twelve or more sessions.

In order to address the rights of young people to information about sexuality, multiple topics need to be covered. In order to reduce sexual risk-taking among young people, both risk and protective factors that affect decision-making need to be addressed. Both of these approaches take time: nearly all the programmes in schools found to have a positive effect upon long-term behaviour have included 12 or more sessions, and sometimes 30 or more sessions, that last roughly 50 minutes or so.

### 3. Include sequential sessions over several years.

To maximise learning, different topics need to be covered in an age-appropriate manner over several years. When giving young people clear messages

about behaviour, it is also important to reinforce those messages over time. Most of the programmes found to have enduring behavioural effects at two or more years follow-up have either involved the provision of sequential sessions over the course of two or three years, or else they are programmes in which most sessions have been provided during the first year and followed up with 'booster' sessions delivered months, or even years, later. This enables more sessions to be provided than might otherwise have been possible. It also makes it possible to reinforce important concepts over the course of several years. A few of these programmes have also implemented school- or community-wide activities over subsequent years. Thus, students could be exposed to the curriculum within the classroom for two or three years and then their learning could be reinforced through school or community-wide components in subsequent years.

### 4. Cover topics in a logical sequence.

Topics should be taught in a logical sequence. Many effective curricula focus first upon strengthening motivation to avoid STI/HIV infection and pregnancy by emphasising susceptibility to and severity of these, before going on to address the specific knowledge, attitudes and skills required to avoid them.

### 5. Employ educationally sound methods that actively involve participants and assist them to personalise information.

A broad range of participatory teaching methods have been used in the implementation of effective curricula. Typically these promote the active involvement of students in a task or activity, conducted in the classroom or community, followed by a period of discussion or reflection in order to draw out specific learning. Methods need to be matched to specific learning objectives.

### 6. Employ activities, instructional methods and behavioural messages that are appropriate to young people's culture, developmental age and sexual experience.

To be maximally effective, curricula must be consistent with the community, culture, age and sexual experience of students. Some effective curricula have been designed for specific racial or ethnic groups. These programmes draw attention to the high rates of HIV, other STIs or pregnancy among those groups and emphasise the need for young

people to avoid unprotected sexual activity as a way of being responsible for themselves and their communities. Other curricula have been designed specifically for young women, emphasising that young women can be powerful and in control of sexual situations (i.e. by not having sexual intercourse when they do not want to and always using a condom if they have sexual intercourse). Given the much higher rates of HIV infection among men-who-have-sex-with-men, efforts are underway in some countries to develop specific curricula for young men-who-have-sex-with-men<sup>16</sup>.

Teaching methods used in effective curricula are consistent with the developmental age of the students. Activities for younger students typically included more basic information, less advanced cognitive tasks, and less complex activities.

## **7. Include homework assignments to increase communication with parents or other adults.**

The most effective way to increase parent-to-child communication about sexuality is to provide student homework assignments to discuss selected topics with parents or other trusted adults. Such assignments can begin with relatively safe topics and progress towards more sensitive ones.

Some programmes prepare parents by providing them with relevant information or else help them acquire skills to enable them to talk more comfortably with their own children about sexual matters. In communities where parents may not be adequately informed about important reproductive health issues, a concentrated programme for parents may also be needed.

## **8. Address gender issues and sensitivities in both the content and teaching approach.**

Gender affects the experience of sexuality, sexual behaviour and reproductive health. Gender discrimination is common and young women often have less power or control in their relationships, making them more vulnerable, in some settings, to abuse and exploitation by older men. Men may also feel pressure from their peers to fulfil male stereotypes.

In order to be effective at reducing sexual risk behaviour, effective curricula need to examine and address these gender inequalities and stereotypes. For example, they

need to discuss the special circumstances faced by young women (or young men) and generate effective methods of avoiding unwanted or unprotected sexual intercourse in those situations. Such activities might also contribute in a small way to the reduction of entrenched gender inequality and stereotyping.

## **Important contextual factors to consider**

In addition to these characteristics of effective programmes, the following key contextual factors also need to be addressed, even if a rigorous evidence base in support of such efforts is not yet available.

### **9. Ensure that a supportive policy environment is in place.**

The sensitive and sometimes controversial nature of sexuality education makes it important that supportive policies are in place, demonstrating that the delivery and curricula of sexuality education are a matter of institutional policy rather than the personal choice of an individual teacher. Such policies are usually developed primarily by the national ministries of education or health, but in some settings they need to be reinforced or sanctioned at state or local level.

Programmes are more likely to run smoothly when they are implemented within appropriate, overarching national development frameworks, together with relevant policies on health (e.g. HIV and AIDS) and social issues (e.g. discrimination or exclusion).

These policies are best developed in consultation with key stakeholders, such as teachers' unions, faith communities, NGOs and other representatives of civil society, including young people. For example, robust policies in support of sexual well-being such as zero tolerance of sexual harassment, abuse, violence and discrimination give clear messages to staff and students alike. Where laws or policies exist that could preclude the implementation of effective programmes, advocacy may need to be undertaken in order to pave the way for the introduction of sexuality education programmes.

These programmes may need to undergo official review and approval, teacher accreditation, grade-level sequencing, testing and other requirements in order to comply with existing policy and practice.



## 10. Select capable and motivated educators to implement the curriculum.

The qualities of the educators can have a huge impact on the effectiveness of the curriculum. Those who deliver curricula should be selected through a transparent process that identifies relevant and desirable characteristics. These include: an interest in teaching the curriculum; personal comfort discussing sexuality; ability to communicate with students; and skill in the use of participatory learning methodologies. If they lack knowledge about the topic, that knowledge can be provided by training (see next characteristic). If it is mostly men who are likely to be selected as educators, then strategies can be implemented to recruit more women.

Educators may be the regular classroom teachers (especially health education teachers) or specially trained teachers who only teach sexuality education and move from classroom to classroom covering all of the relevant classes in the schools. The advantages of general classroom teachers include the following: they are part of the school structure; they may be known and trusted by the community; they have already established relationships with learners; and they can integrate sexuality education messages into different subjects. The advantages of using specialist sexuality education educators include: they can be specially trained to cover this sensitive topic and to implement participatory activities; they can be provided with regularly updated information; and they can be linked to community-based reproductive health services. Studies have demonstrated that programmes can be effectively delivered by both groups of educators.

Debate continues regarding the relative potential efficacy of peer-led versus adult-led delivery of sexuality education curricula. There is stronger evidence that adult-led (as compared to peer-led) programmes demonstrate positive effects on behaviour. However, this reflects the larger number of studies that have focused on adult-led programmes. Three randomised trials and a formal meta-analysis comparing the respective effectiveness of adult- and peer-led programmes have been inconclusive. None have found strong evidence that adult-led programmes are more or less effective than peer-led programmes.

## 11. Provide quality training to educators.

For teachers, delivering sexuality education often involves both new concepts and new learning methods and thus specialised training is important. This training should have clear goals and objectives, should teach and provide practice in participatory learning methods, should provide a good balance between learning content and skills, should be based on the curriculum that is to be implemented, and should provide opportunities to rehearse key lessons in the curriculum. All of this can increase the confidence and capability of the educators. The training should help educators distinguish between their personal values and the health needs of the learners. It should encourage educators to teach the curriculum completely and with fidelity, not selectively. It should address challenges that will occur in some communities e.g. very large class sizes and pressures of teaching to exams. It should last long enough to cover the most important knowledge content and skills and to allow participants time to personalise the training and raise questions and issues. If possible, it should address teachers' own concerns about their sexual health and HIV status, if appropriate. Finally, it should be taught by experienced and knowledgeable trainers. At the end of the training, participants' feedback on the training should be solicited.

## 12. Provide on-going management, supervision and oversight.

Because sexuality education is not well established in many schools, school managers should provide encouragement, guidance and support to teachers involved in delivering it. Supervisors should make sure the curriculum is being implemented as planned, that all parts are fully implemented (not just the biological parts that often may be part of examinations), and that teachers have access to support in responding to new and challenging situations as these arise in the course of their work. Supervisors should also keep abreast of important developments in the field of sexuality education so that any necessary adaptations can be made to the school's programme.

### 13. Create a safe environment for youth to participate and learn – link with quality education.

In order for students to be able to pay attention and feel comfortable participating in sexuality education group activities, they need to feel safe. It is therefore essential to create a conducive environment for sexuality education. This usually includes the establishment, at the outset, of a set of ground rules to be followed during teaching and learning of sexuality education. Typical examples include: not expressing 'put-downs'; not asking personal questions; respecting the right not to answer questions; recognising that all questions are legitimate; not interrupting; respecting the opinions of others; and maintaining confidentiality. In order to promote participation, some curricula also encourage positive reinforcement of student participation. Some programmes separate students into same-sex groups, for part or all of a programme. Sexual relationships between teachers and students are utterly incompatible with a safe learning environment.

Safety in the classroom environment should be reinforced by anti-homophobic and anti-gender discrimination policies that are consistent with the curriculum. More generally, the ethos of the school should be aligned with the values and goals of the curriculum. Schools need to be 'safe places' where learners can express themselves without concern about being put down, humiliated, rejected or mistreated.

## Programme development

The process of developing or selecting and adapting a curriculum can have a large impact on its effectiveness. Simply incorporating the principles above and covering the learning objectives in the next section will not ensure maximum effectiveness. The following steps should be completed to increase effectiveness:

### 14. Involve multiple people with expertise in human sexuality, sexual health and young people's sexual behaviour.

Just like mathematics, science, languages and other fields, human sexuality is an established field based on an extensive body of research and knowledge. Thus, people familiar with this research and knowledge should be involved in developing or selecting and adapting curricula. In addition, if programmes are designed to reduce sexual risk behaviour, then the curriculum

developers must be knowledgeable about what risky behaviours young people are actually engaging in at different ages, what environmental and internal cognitive factors affect those behaviours, and how best to address those factors.

### 15. Involve young people in the development of the curriculum.

Sexuality education programmes can be more attractive to young people and more effective if young people play a role in developing the curriculum. There are multiple roles that young people can play. For example, they can identify some of their particular concerns and commonly held beliefs about sexuality, suggest activities that address such concerns, help make role-play scenarios more realistic, and suggest refinements in all activities during pilot-testing.

### 16. Assess relevant needs and assets of the target group.

While there is considerable commonality among young people in terms of their needs regarding sexuality, there are also many differences across communities, settings and age groups in their knowledge, their beliefs, their attitudes and skills, and their reasons for failing to avoid unwanted, unintended and unprotected sexual intercourse. Because effective sexuality education programmes should strive to address these reasons, they must be identified.

It is also important to build upon young people's existing knowledge, positive attitudes and skills. Thus, effective programmes should build on these assets as well as address deficits.

The needs and assets of young people can be assessed through focus groups with young people and interviews with professionals who work with them as well as reviews of research data from the target group or similar populations.

### 17. Design activities sensitive to community values and consistent with available resources (e.g. staff time, staff skills, facility space and supplies).

This is an important step for all programmes. While this characteristic may seem obvious, there are numerous examples of people who developed curricula that could

not or were not fully implemented because they were not sensitive to community values and resources; consequently, these programmes were not fully implemented or were prematurely terminated.

**18. Pilot-test the programme and obtain on-going feedback from the learners about how the programme is meeting their needs.**

Pilot-testing the programme with individuals representing the target population allows for adjustments to be made to any programme component before formal implementation. This gives programme developers an opportunity to fine-tune the programme as well as to discover important and needed changes. For example, they may change a scenario in a role play to make it more appropriate, or change wording in a role play so that it is more familiar or understandable to the programme participants. During pilot-testing, conditions should be as close to those prevailing in the intended implementation setting. The entire curriculum should be pilot-tested and practical feedback from participants should be obtained, especially on what did and did not work and on ways to make weak elements stronger and more effective.

**19. Cover a comprehensive array of topics that address the needs of young people (see the learning objectives in Part II).**

Programme characteristics 1-18 outlined above address human rights and lead to behaviour change (see Table 3a). Characteristic 19 only addresses human rights.

## Characteristics necessary for achieving behaviour change

**1. Use a logic model approach that specifies the health goals, the types of behaviour affecting those goals, the risk and protective factors affecting those types of behaviour, and activities to change those risk and protective factors.**

A logic model is a process or tool used by programme developers to plan and design a programme. Most effective programmes that changed behaviour, and especially those that reduced pregnancy or STI rates, used a clear four-step process for creating the curriculum: 1) they identified the health goals (e.g.

reducing unintended pregnancy or HIV/STIs); 2) they identified the specific behaviours that affected pregnancy and HIV/STI rates and that they could change; 3) they identified the cognitive (or sexual psychosocial) factors that affect those behaviours (e.g. knowledge, attitudes, norms, skills, etc); and 4) they created multiple activities to change each factor. This logic model was the theory or basis for their effective programmes.

**2. Involve multiple people with expertise in theory about behaviour change, research about factors affecting sexual behaviour, effective instructional methods for changing those factors, and sexuality and STI/HIV education to develop the curriculum.**

To create programmes that reduce sexual risk behaviour, curriculum developers must use theory and research about the factors affecting sexual behaviour to identify the factors the programme will address. Then, the curriculum developers must use effective instructional methods to address each of those factors. This requires that they are proficient in theory, psychosocial factors affecting sexual behaviour and effective teaching methods for changing those factors. And, of course, they need knowledge about other sexuality education programmes that changed behaviour, especially those that addressed similar communities and young people.

**3. Focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy.**

Effective curricula are focused curricula. Specifically in relation to sexuality education, this means focusing upon young people's susceptibility (for example, to HIV, other STIs or pregnancy) and the negative consequences of these occurrences. Effective curricula give clear messages about these goals: i.e. if young people have unprotected sexual intercourse on a regular basis they are potentially at risk of HIV, other STIs or of becoming pregnant (or of causing a pregnancy), and that there are negative consequences associated with these occurrences. In the process of doing this, effective curricula motivate young people to want to avoid STIs and unintended pregnancy.

#### 4. **Focus narrowly on specific sexual and protective behaviours leading directly to these health goals.**

To eliminate the risk of acquiring HIV or other STIs, young people need to avoid unprotected sexual intercourse (vaginal, anal or oral). If they do have sexual intercourse and wish to reduce the risks of HIV, STIs or pregnancy, they should use condoms correctly and consistently, reduce the number of sexual partners, avoid concurrent sexual partnerships, remain in mutually exclusive sexual relationships, be tested (and treated as necessary) for STIs and vaccinated against those STIs for which vaccinations exist (i.e. Human Papilloma Virus (HPV) and Hepatitis B). Men can also further reduce the risk of becoming infected with HIV through male circumcision<sup>17</sup>. To reduce the risk of pregnancy, young people should avoid vaginal sexual intercourse, reduce the frequency of unprotected sexual intercourse, or else use an effective method of contraception.

Effective curricula focus on particular behaviours in a variety of ways. First, they talk explicitly about sexual intercourse, having fewer partners and condom use and contraceptive use. For example, they have identified the pressures to have sexual intercourse facing young people and suggested ways of responding to this. Curricula have identified specific situations that could lead to unwanted or unprotected sexual intercourse and explored coping strategies. During sessions, young people learn how to use condoms or contraceptives correctly. They also learn ways of overcoming barriers to obtaining or using these, for example, identifying specific places where young people can obtain low cost and confidential services (including testing and treatment for STIs).

A few effective programmes have established direct and close linkages with nearby reproductive health services. These have facilitated the use of contraception and STI testing, for example.

#### 5. **Give clear messages about behaviours to reduce risk of STIs or pregnancy.**

Providing clear messages about risk and protective behaviours appears to be one of the most important characteristics of effective programmes. Nearly all effective programmes repeatedly, and in a variety of ways, reinforce clear and consistent messages about protective behaviours. In fact, most activities in the curriculum are designed to change behaviours so that they will be consistent with the message. Given that

the majority of the effective programmes are designed to reduce HIV and other STIs, the most common messages disseminated are that young people should either avoid sexual intercourse or else use a condom every time they have sexual intercourse with every partner. Some effective programmes also emphasise being faithful and avoiding multiple or concurrent sexual partners. Culturally-specific messages in some sub-Saharan African countries also emphasise the dangers of ‘sugar daddies’ (older men who offer gifts or treats, often implicitly in return for sexual intercourse). Other programmes encourage testing and treatment for STIs including HIV. Programmes concerned with pregnancy prevention tend to emphasise that young people should use contraception every time they have sexual intercourse. Some programmes identify and appeal to important community values e.g. ‘be proud’, ‘be responsible’, or ‘respect yourself’. When programmes do appeal to these values, they make very clear the specific sexual and protective behaviours that are consistent with these values.

#### 6. **Address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid these and how to get out of them.**

It is important, ideally with the input of young people themselves, to identify the specific situations in which young people are likely to be most pressured to have sexual intercourse and to rehearse strategies for avoiding and getting out of them. In those communities where drug and/or alcohol use leads to unprotected sexual intercourse, it is important also to address the impact of drugs and alcohol on sexual behaviour.

#### 7. **Focus on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme (e.g. knowledge, values, attitudes, norms, skills).**

Risk and protective factors have an important impact on young people’s decision-making about sexual behaviour. These include internal cognitive factors, such as knowledge, values, perception of peer norms, attitudes, skills and intentions, as well as external factors, such as access to adolescent-friendly health and social support services. Curriculum-based programmes, especially those in schools, typically focus primarily on internal cognitive factors, but they also describe how to access reproductive health services.

**8. Implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors.**

Multiple activities are usually necessary to address each risk and protective factor; thus, many activities are needed. This is one reason why successful programmes usually last for at least twelve to twenty sessions.

In addition, the activities need to include instructional strategies that are designed to change the associated risk or protective factors e.g. role playing to increase self-efficacy and skills to refuse unwanted sexual intercourse or possible situations that might lead to unwanted sexual intercourse.

**9. Provide scientifically accurate information about the risks of having unprotected sexual intercourse and the effectiveness of different methods of protection.**

Information within a curriculum should be evidence-based, scientifically accurate and balanced, neither exaggerating nor understating the risks or effectiveness of condoms or other forms of contraception.

**10. Address perceptions of risk (especially susceptibility).**

Effective curricula focus on both the susceptibility to and the severity of HIV, other STIs and unintended pregnancy. Personal testimony, simulations and role playing have all been found to be useful adjuncts to statistical and other factual information in exploring the concepts of susceptibility and severity.

**11. Address personal values about having sexual intercourse and/or having multiple partners and perception of family and peer norms about having sexual intercourse and multiple partners.**

Personal values have significant impact on sexual behaviour. Effective programmes have promoted the following values: abstinence; non-sexual ways of demonstrating affection; and being in long-term, loving, mutually faithful sexual relationships. These values have been explored through surveys, role plays and homework assignments, including communication with parents.

**12. Address individual attitudes and peer norms towards condoms and contraception.**

Similarly, personal values and attitudes also affect condom and contraceptive use. Thus, effective programmes have presented clear messages about these, together with accurate information about their effectiveness. They have also helped students to explore their attitudes towards condoms and contraception and identified perceived barriers to their use e.g. difficulties obtaining and carrying condoms, possible embarrassment when asking one's partner to use a condom, or any difficulties actually using a condom and then discussed methods of overcoming these barriers

**13. Address both skills and self-efficacy to use those skills.**

In order to avoid unwanted or unprotected sexual intercourse, young people need the following: the ability to refuse unwanted, unintended or unprotected sexual intercourse; the ability to insist on using condoms or contraception; and the ability to obtain and use these correctly. The first two require communication with a partner. Role playing, representing a range of typical situations, is commonly used to teach these skills with elements of each skill identified before rehearsal in progressively complex scenarios. Condom use and acquisition skills are typically acquired through demonstration and visits to places where they are available.

Programme characteristics 1 – 13 all lead to behaviour change (see Table 3b).

**Table 3a. Summary of characteristics that address human rights and lead to behaviour change**

Characteristics
1. Implement programmes in schools and other youth-oriented organizations that reach large numbers of young people.
2. Implement programmes that include at least twelve or more sessions.
3. Include sequential sessions over several years.
4. Cover topics in a logical sequence.
5. Employ educationally sound methods that actively involve participants and assist them to personalise information.
6. Employ activities, instructional methods and behavioural messages that are appropriate to young people's culture, developmental age and sexual experience.
7. Include homework assignments to increase communication with parents or other adults.
8. Whenever appropriate, address gender issues and sensitivities in both the content and teaching approach.
9. Assure a supportive policy environment is in place for instruction.
10. Select capable and motivated educators to implement the curriculum.
11. Provide quality training to educators.
12. Provide on-going management, supervision and oversight of educators.
13. Create a safe environment for youth to participate and learn.
14. Involve multiple people with expertise in human sexuality, sexual health and young people's sexual behaviour.
15. Involve young people in the development of the curriculum.
16. Assess relevant needs and assets of the target group.
17. Design activities consistent with community values and available resources (e.g. staff time, staff skills, facility space and supplies).
18. Pilot-test the programme and obtain on-going feedback from the learners about how the programme is meeting their needs.

**Table 3b. Summary of characteristics that lead to behaviour change**

Characteristics
1. Use a logic model approach that specifies the health goals, the types of behaviour affecting those goals, the risk and protective factors affecting those types of behaviour, and activities to change those risk and protective factors.
2. Involve multiple people with expertise in theory about behaviour change, research about factors affecting sexual behaviour, effective instructional methods for changing those factors, and sexuality and STI/HIV education to develop the curriculum.
3. Focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy.
4. Focus narrowly on specific sexual and protective behaviours leading directly to these health goals.
5. Give clear messages about these behaviours to reduce risk of STIs or pregnancy.
6. Address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid those situations.
7. Focus on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme (e.g. knowledge, values, attitudes, norms, skills).
8. Implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors.
9. Provide scientifically accurate information about the risks of having sexual intercourse and methods of avoiding sexual intercourse or using protection.
10. Address perceptions of risk (especially susceptibility).
11. Address personal values about having sexual intercourse or multiple partners and perception of family and peer norms about having sexual intercourse and multiple partners.
12. Address individual attitudes and peer norms toward condoms and contraception.
13. Address both skills and self-efficacy to use those skills.

# **Part 2:**

## **Topics and learning objectives**



This section of the *International Guidelines* presents the ‘basic minimum package’ of topics and learning objectives for a comprehensive sexuality education programme. The goals of the topics and learning objectives are to:

- provide accurate information about topics that children and young people are curious about and about which they have a need to know;
- provide children and young people with opportunities to explore values, attitudes and norms concerning sexual and social relationships;
- promote the acquisition of skills; and
- encourage children and young people to assume responsibility for their own behaviour and to respect the rights of others.

As a comprehensive package, all learning objectives address children’s and young people’s right to information and education. However, while only some of these learning objectives are specifically designed to reduce risky sexual behaviour most learning objectives will attempt to change social norms, facilitate communication of sexual issues, remove social and attitudinal barriers and increase knowledge.

# 1. Age range

The *topics and learning objectives* are intended for young people at primary and secondary school levels. However, many people have not received any sexuality education at those levels and so learners in tertiary institutions may also benefit from these *International Guidelines*. Indeed, the need for sexuality education at tertiary level may be especially critical, given that many students will be living away from home for the first time, may develop relationships, and be sexually active. In addition, the topics and learning objectives may prove useful for teacher training and curriculum development or simply as a checklist to review existing curricula and programmes.

It is equally important to provide sexuality education to children and young people out of school, especially for those who may be marginalised for a variety of reasons, and particularly vulnerable to an early, unprepared sexual debut and sexual exploitation and abuse.

The topics and learning objectives address four age groups and corresponding levels:

1. ages 5 to 8 (Level 1)
2. ages 9 to 12 (Level 2)
3. ages 12 to 15 (Level 3)
4. ages 15 to 18+ (Level 4).

There is a deliberate overlap between levels 3 and 4 in order to accommodate the broad age range of learners who might be in the same class. Level 4 addresses learners from ages 15 to 18+ to acknowledge that some learners in the secondary level may be older than 18 and that the topics and learning objectives can also be used with more mature learners in tertiary institutions. All information discussed with the above-mentioned age groups would be in keeping with their cognitive abilities as to include children and young people with intellectual/learning disabilities.

The sexual and reproductive health needs and concerns of children and young people, as well as the age of sexual debut, vary considerably within and across regions. This, in turn, is likely to affect the perceived appropriateness of particular learning objectives when developing curricula, materials and programmes. Learning objectives can, of course, be adjusted. However, this should be done in response to the available data and evidence rather than because of personal discomfort or perceived opposition.



## 2. Components of learning

The topics and learning objectives cover four components of the learning process:

- 1. Information:** sexuality education provides accurate information about human sexuality, including: growth and development; sexual anatomy and physiology; reproduction; contraception; pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; gender rights; empowerment; equality and gender roles; sexual behaviour; sexual diversity; sexual pleasure; sexual abuse; gender-based violence; and harmful traditional practices.
- 2. Values, attitudes and social norms:** sexuality education offers students opportunities to explore values, attitudes and norms (personal, family, peer and community) in relation to sexual behaviour, health, risk-taking and decision-making and in consideration of the principles of tolerance, respect, gender rights and equality.
- 3. Interpersonal and relationship skills:** sexuality education promotes the acquisition of skills in relation to: decision-making; assertiveness; communication; negotiation; and refusal. Such skills can contribute to better and more productive relationships with family members, peers, friends and romantic or sexual partners.
- 4. Responsibility:** sexuality education encourages students to assume responsibility for their own behaviour as well as their behaviour towards other people through the strategies of: respect; acceptance; tolerance and empathy for all people regardless of their health status or sexual orientation; insisting on gender equality; resisting early, unwanted or coerced sex; and practising safer sex, including the correct and consistent use of condoms and contraceptives.

## 3. Points of Entry

Decisions need to be made about whether sexuality education should be: taught as a stand-alone subject (as it is in Malawi); integrated within an existing mainstream subject, such as health or biology (as it is in Jamaica); delivered across several other subjects, such as civics, health and biology (as in Nigeria); or included in guidance and counselling (up until recently in Kenya).

Decisions will be influenced by general educational policies, the availability of resources (including the availability of supportive school administration, trained teachers and materials), competing priorities in the school curriculum, the needs of learners, community support for sexuality education programmes and timetabling issues. A pragmatic response might acknowledge that, while it would be ideal to introduce sexuality education as a separate subject, it may be more practical to build upon and improve what teachers are already teaching, and look to integrate it within existing subjects such as social science, biology or guidance and counselling.

### Box 4. Sexuality education – Points of entry experiences in five countries

#### Jamaica

In Jamaica, sexuality education is taught as a stand-alone subject by a range of teachers including those responsible for biology, health, home and family living. The strategy of teaching sexuality education as a stand-alone subject ensures that competing priorities do not prevent it from being taught at all.

#### Malawi

In Malawi, sexuality education is a stand-alone and examinable subject from primary school onwards. Sexuality education is taught by trained teachers using specifically designed materials.

#### Mexico

In Mexico, sexuality education is integrated within various parts of the curriculum such as science and civics education, in recognition of the fact that sexuality is part of many aspects of life. Sexuality education may become a separate subject for learners (aged 15-18 years) in upper secondary school.

#### United Republic of Tanzania

In the United Republic of Tanzania, sexuality education is integrated within carrier subjects such as a science and civics education. The Tanzanian case proves that sexuality education does not need to be made an entirely separate subject in order to be examinable.

#### Viet Nam

In Viet Nam, the Ministry of Health is in the process of developing a compulsory extra-curricular component, which will complement intra-curricular content. The strategy also makes use of participatory approaches and peer support reinforced by a parallel parental programme.

## 4. Structure

The overarching topics under which learning objectives have been defined are organized around six key concepts:

1. Relationships
2. Values, attitudes and skills
3. Culture, society and law
4. Human development
5. Sexual behaviour
6. Sexual and reproductive health

Each topic is linked to specific learning objectives, grouped according to the four age levels. The learning objectives are the intended outcomes of working on particular topics. Learning objectives are defined at the level when they should be first introduced, but they need to be reinforced across different age levels. When a programme begins with older students, it may be necessary to cover topics and learning objectives from earlier age levels. Based on needs and country/region-specific characteristics, such as social and cultural norms and epidemiological context, the contents of the learning objectives could be adjusted to be included within earlier or later age levels. However, most experts believe that children and young people want and need sexuality and sexual health information as early and comprehensively as possible, and have a need to receive this important information.

## 5. Presentation

The tables below reflect a broad, rights-based approach to sexuality education. They draw from the evidence base concerning behaviour-change curricula, but go beyond this to include topics and learning objectives based upon experiences in the field, together with expert opinion, in order to provide a comprehensive 'menu' for curriculum development.

## 6. Overview of key concepts and topics

<b>Key Concept 1: Relationships</b> <b>Topics:</b> 1.1 Families 1.2 Friendship, Love and Romantic Relationships 1.3 Tolerance and Respect 1.4 Long-term Commitment, Marriage, and Parenting	<b>Key Concept 2: Values, Attitudes and Skills</b> <b>Topics:</b> 2.1 Values, Attitudes and Sources of Sexual Learning 2.2 Norms and Peer Influence on Sexual Behaviour 2.3 Decision-making 2.4 Communication, Refusal and Negotiation Skills 2.5 Finding Help and Support	<b>Key Concept 3: Culture, Society and Law</b> <b>Topics:</b> 3.1 Sexuality, Culture and Law 3.2 Sexuality and the Media 3.3 The Social Construction of Gender 3.4 Gender-Based Violence, Sexual Abuse and Harmful Traditional Practices
<b>Key Concept 4: Human Development</b> <b>Topics:</b> 4.1 Sexual and Reproductive Anatomy and Physiology 4.2 Reproduction 4.3 Puberty 4.4 Body Image 4.5 Body Rights	<b>Key Concept 5: Sexual Behaviour</b> <b>Topics:</b> 5.1 Sex, Sexuality and the Sexual Life Cycle 5.2 Shared Sexual Behaviour and Sexual Response	<b>Key Concept 6: Sexual and Reproductive Health</b> <b>Topics:</b> 6.1 Pregnancy Prevention 6.2 Understanding, Recognising and Reducing the Risk of STIs including HIV 6.3 HIV and AIDS Stigma, Care, Treatment and Support

# Key Concept 1

## – Relationships

### 1.1 Families

#### Learning Objectives for Level I (5-8)

*Define the concept of 'family' with examples of different kinds of family structures*

##### Key Ideas:

- Many different kinds of families exist around the world (e.g. two-parent, single parent, child-headed, guardian-headed, extended and nuclear families, same-sex couple parents, etc.)
- Family members have different needs and roles
- Family members can take care of each other in many ways, though sometimes they may not want to or be able to
- Gender inequality is often reflected in the roles and responsibilities of family members
- Families are important in teaching values to children

#### Learning Objectives for Level II (9-12)

*Describe the roles, rights and responsibilities of different family members*

##### Key Ideas:

- Importance of gender equality in terms of roles and responsibilities within families
- Importance of communication within families, in particular between parents and children
- Importance of parents guiding and supporting their children's decisions
- Families help children to acquire values and influence their personality
- Health and disease can affect families in terms of their structure, roles and responsibilities

#### Learning Objectives for Level III (12-15)

*Describe how responsibilities of family members change as they mature*

##### Key Ideas:

- Family relationships should be based on mutual caring, respect and gender equality
- Increasing independence is usually accompanied by increasing responsibility for self and others
- Conflict and misunderstandings between parents and children are common, especially during puberty, and usually resolvable with mutual respect
- Love, cooperation, gender equality and mutual respect are important for good family functioning and healthy relationships
- As they grow up, children's worlds and affections expand beyond the family. Friends and peers become particularly important
- Forced marriages and child marriages are harmful and usually illegal

#### Learning Objectives for Level IV (15-18)

*Discuss how sexual and relationships issues can impact on the family - e.g. disclosing an HIV-positive status, an unintended pregnancy, abortion, being in a same-sex relationship*

##### Key Ideas:

- Families can survive crises when they support one another with mutual respect
- Family members' roles may change when a young family member discloses an HIV-positive status, becomes pregnant, has an abortion<sup>18</sup>, refuses an arranged marriage or comes out as being gay
- There are support systems that family members can turn to in times of crisis

## 1.2 Friendship, Love and Relationships

### Learning Objectives for Level I (5-8)

#### *Define a 'friend'*

##### **Key Ideas:**

- Different kinds of friends (e.g. good friends versus bad friends, boyfriends, girlfriends)
- Feelings, trust, sharing, empathy and solidarity
- Different kinds of love and different ways of expressing it
- Key characteristics of different kinds of relationships

### Learning Objectives for Level II (9-12)

#### *Identify skills needed for managing relationships*

##### **Key Ideas:**

- Different ways to express friendship and love to another person
- Friendships and love help people feel good about themselves
- Gender role stereotypes can affect all kinds of personal relationships
- The need to promote gender equality for healthier relationships
- Abusive relationships and why they happen
- Characteristics of healthy and unhealthy (abusive) relationships
- Different kinds of relationship abuse

### Learning Objectives for Level III (12-15)

#### *Differentiate between different kinds of relationships*

##### **Key Ideas:**

- Benefits of friendship
- Sometimes close relationships can become sexual
- Differences between love, friendship, infatuation and sexual attraction
- Friends can influence one another positively and negatively
- Characteristics and qualities of healthy and unhealthy relationships
- Gender stereotypes, gender roles and romantic relationships
- Links between gender role stereotypes and relationship abuse and violence

### Learning Objectives for Level IV (15-18)

#### *Identify relevant laws concerning abusive relationships*

##### **Key Ideas:**

- Legal sanctions against abuse
- Concept of empowerment
- A person's rights and responsibilities regarding abusive relationships
- Recognising and reporting abuse
- Know where to find support

# Key Concept 1

## – Relationships

### 1.3 Tolerance and Respect

#### Learning Objectives for Level I (5-8)

##### *Define 'respect'*

##### **Key Ideas:**

- Concepts of tolerance, acceptance and respect
- Every human being is unique and valuable and can contribute to society by being a friend, being in a relationship and by giving love, including disabled people and people living with HIV
- Every human being deserves respect
- Making fun of people is harmful

#### Learning Objectives for Level II (9-12)

##### *Define the concepts of bias, prejudice, stigma, intolerance, harassment, rejection and bullying*

##### **Key Ideas:**

- Harassing or bullying people particularly those perceived as different (regardless of health status, colour, origin or sexual orientation) is disrespectful, hurtful and a violation of human rights
- Concepts of stigma, discrimination, homophobia, transphobia and abuse of power
- Defending people who are being harassed or bullied

#### Learning Objectives for Level III (12-15)

##### *Explain why discrimination and bullying are harmful*

##### **Key Ideas:**

- It is harmful to stigmatise or discriminate against people because of disability, HIV status, gender identity or sexual orientation
- Consequences of stigma and discrimination, including self-stigma
- Speaking out against bias and intolerance
- Knowing where to find help when people are being harmed

#### Learning Objectives for Level IV (15-18)

##### *Explain why it is important to challenge discrimination against those perceived to be "different"*

##### **Key Idea:**

- Impact of discrimination upon individuals, communities, society
- Cite supportive laws

## 1.4 Long-term Commitments, Marriage and Parenting

### Learning Objectives for Level I (5-8)

*Explain the concepts of 'family' and 'marriage'*

#### Key Ideas:

- Some people choose their marriage partners, others have arranged marriages
- Separation and divorce
- Different family structures affect children's living arrangements, roles and responsibilities

### Learning Objectives for Level II (9-12)

*Explain the key features of long-term commitments, marriage and parenting*

#### Key Ideas:

- Legal restrictions on the right to marriage and have children
- Every person has the right to decide whether to become a parent including disabled people and people living with HIV
- Child marriage and forced marriage are inconsistent with basic human rights
- Responsibilities of parenting
- Adults can become parents in several ways: intended and unintended pregnancy, adoption, fostering, use of assisted fertility technologies and surrogate parenting

### Learning Objectives for Level III (12-15)

*Identify the key responsibilities of marriage and long-term commitments*

#### Key Ideas:

- Negative social and health consequences of early marriage, child marriage and teenage parenting
- Roles and responsibilities of parents/guardians
- Impact of culture and gender role stereotypes on roles of parents
- Difficulties and challenges associated with teenage parenting
- Divorce and coping with its effects

### Learning Objectives for Level IV (15-18)

*Identify key physical, emotional, economic, and educational needs of children and associated responsibilities of parents*

#### Key Ideas:

- Qualities needed for successful loving relationships
- Challenges of long-term commitments
- Coping with difficulties in relationships
- Reasons to have children (or not)

# Key Concept 2

## – Values, Attitudes and Skills

### 2.1 Values and Attitudes and Sources of Sexual Learning

#### Learning Objectives for Level I (5-8)

*Define values and identify three important personal values*

#### Key Ideas:

- Values are strong beliefs held by individuals, families and communities about important issues
- Values and beliefs guide decisions about life and relationships
- Individuals, peers, families and communities may have different values

#### Learning Objectives for Level II (9-12)

*Identify sources of values, attitudes and sexual learning*

*Demonstrate confidence in discussing and asking questions about basic sexual matters*

#### Key Ideas:

- Values regarding gender, relationships, intimacy, love, sexuality and reproduction influence personal behaviour and decision-making
- Cultural values affect male and female gender role expectations and equality

#### Learning Objectives for Level III (12-15)

*Describe their own personal values in relation to a range of sexuality and reproductive health issues*

*Provide clear examples of how personal values affect their own decisions and behaviour*

#### Key Idea:

- The need to know one's own values, beliefs and attitudes and how to stand up for them
- The need to tolerate and respect differences in other people's values, beliefs and attitudes

#### Learning Objectives for Level IV (15-18)

*Explain how to behave in ways that are consistent with ones' own values*

#### Key Ideas:

- Relationships benefit when people respect each other's values
- Parents teach and model their values to their children, are able to reflect on this interaction and can respect the fact that their children might from different values



## 2.2 Norms and Peer Influence on Sexual Behaviour

### Learning Objectives for Level I (5-8)

#### *Define peer pressure*

##### **Key Ideas:**

- The right to self-determination
- Examples of different kinds of peer pressure
- Resisting influence of negative peer pressure

### Learning Objectives for Level II (9-12)

#### *Describe social norms and their influence on behaviour*

##### **Key Ideas:**

- Social norms influence values and behaviour, including sexual values and behaviour
- Assertive behaviour
- Resisting the influence of negative social norms and peer pressure

### Learning Objectives for Level III (12-15)

#### *Explain how peer influence and social norms influence sexual decisions and behaviour*

##### **Key Ideas:**

- Harmful consequences of all forms of bullying and negative peer pressure
- Ways in which social norms and peer influence can affect individual and group behaviour
- Saying 'yes' and 'no'
- Sticking to one's own decisions about sexual activity

### Learning Objectives for Level IV (15-18)

#### *Demonstrate skills in resisting peer pressure*

##### **Key Ideas:**

- People can stand up for their right to self-determination
- People can make rational decisions about sexual activity
- People can resist negative peer influence in their decision-making

## Key Concept 2

### – Values, Attitudes and Skills

#### 2.3 Decision-Making

##### Learning Objectives for Level I (5-8)

*Identify examples of good and bad decisions and their consequences*

##### Key Ideas:

- Decisions and their consequences
- People have the right to make their own decisions
- Decision-making skills
- Children may need help from adults to make certain decisions

##### Learning Objectives for Level II (9-12)

*Apply the decision-making process to address problems*

##### Key Ideas:

- People have different ways of making decisions
- Steps in the decision-making process
- Anticipating consequences
- Choosing actions with the best outcome
- Influences on decisions (e.g. friends, culture, gender role stereotypes, peers and media)
- Knowing where to find help with decision-making

##### Learning Objectives for Level III (12-15)

*Evaluate advantages, disadvantages and consequences of different decisions*

*Apply the decision -making process to address sexual and/or reproductive health concerns*

##### Key Ideas:

- Barriers to decisions
- Learning how to reflect on the consequences before making decisions
- Decisions can affect people's health, future, and life plans
- Effects of alcohol and drugs on decision-making
- Role of emotions in decision-making

##### Learning Objectives for Level IV (15-18)

*Identify potential legal, social and health consequences of sexual decision-making*

##### Key Idea:

- Defending my right to make my own decisions
- Defending people's right to self-determination

## 2.4 Communication, Refusal and Negotiation Skills

### Learning Objectives for Level I (5-8)

***Demonstrate understanding of different types of communication***

#### Key Ideas:

- Verbal and non-verbal communication
- People have different ways of communicating
- All people have the right to express themselves
- Importance of good communication between friends, with trusted adults and between parents and children
- Communication is used to express rights

### Learning Objectives for Level II (9-12)

***Demonstrate examples of effective and ineffective communication***

#### Key Ideas:

- People have different ways of communicating
- Elements of effective verbal and non-verbal communication
- Different modes of communication and styles
- Importance of good communication between friends, with trusted adults and between parents and children
- Negotiation requires mutual respect, cooperation and often compromise from all parties
- Ways in which gender can affect decision-making between people
- Assertive communication

### Learning Objectives for Level III (12-15)

***Demonstrate confidence in using negotiation and refusal skills***

#### Key Ideas:

- Barriers to effective communication
- Using communication skills to resist unwanted sexual pressure
- If sexual active, using communication skills to practice safe and consensual sex
- Role of gender expectations and stereotypes in negotiating and refusing sexual contact

### Learning Objectives for Level IV (15-18)

***Demonstrate effective communication of personal needs and sexual limits***

#### Key ideas:

- Good communication is essential to personal, family, romantic, school and work relationships
- Assertiveness and negotiation skills can sometimes help to resist unwanted sexual pressure or reinforce the intention to practice safer sex

## Key Concept 2

### – Values, Attitudes and Skills

#### 2.5 Finding Help and Support

##### Learning Objectives for Level I (5-8)

*Identify specific ways in which people can help each other*

##### Key Ideas:

- Friends, family, teachers, clergy and community members can and should help each other
- Sources of help in the community
- The right of all people to be protected and supported
- Characteristics of good sources of help

##### Learning Objectives for Level II (9-12)

*Identify specific problems and relevant sources of help*

##### Key Ideas:

- Some problems can be addressed with outside help
- Sources of support in the school and community
- Specific steps involved in obtaining and using condoms and contraception, including emergency contraception

##### Learning Objectives for Level III (12-15)

*Identify appropriate sources of help*

##### Key Ideas:

- Trusted adults who might be able to provide help
- Shame/guilt should not be a barrier to seeking help
- Ways to seek additional help, resources, or information
- Potential uses and dangers of using media (e.g. internet) to obtain information or help with a problem
- Right to privacy, respect and confidentiality when seeking help/support
- Specific steps involved in being tested for HIV and STIs
- Places where people can access support for sexual and reproductive health (e.g. counselling, testing and treatment for STIs/HIV; services for contraception, sexual abuse, rape, domestic and gender-based violence, abortion (where legal), homophobia, stigma and discrimination)

##### Learning Objectives for Level IV (15-18)

*Demonstrate appropriate help-seeking behaviour*

##### Key Ideas:

- Right to privacy, respect and confidentiality when seeking help/support
- Stand up for the right to affordable, respectful and confidential help

# Key Concept 3

## – Culture, Society and Law

### 3.1 Sexuality, Culture and Law

#### Learning Objectives for Level I (5-8)

*Identify sources of our information about sex and gender*

##### Key idea:

- People receive messages about sex, gender and sexuality from their cultures and religions

#### Learning Objectives for Level II (9-12)

*Identify key cultural, religious and legal norms and messages about sexuality*

*Demonstrate willingness to listen to the opinions of others regarding sexuality*

##### Key Idea:

- Recognise the importance of culture, society and law in influencing people's well-being
- Define cultural norms and taboos related to sexuality and gender and how they have changed over time
- Identify rites of passage to adulthood

#### Learning Objectives for Level III (12-15)

*Identify key cultural norms and sources of messages relating to sexuality*

##### Key Ideas:

- Sources of messages about sexuality
- Specific messages people receive about sexuality from their culture, religion and society
- Diversity of sexual expression, orientation and cultural restrictions
- Rights of and respect for people with diverse sexual expression and orientation
- Diversity of laws relating to sexual and reproductive health e.g. age of consent, rape, sexual abuse, abortion, sexual orientation
- Impact of culture, norms and laws on personal expressions of gender and sexuality

#### Learning Objectives for Level IV (15-18)

*Explain the concept of sexual and reproductive rights*

*Identify specific legislation affecting the implementation of sexual and reproductive rights*

##### Key Ideas:

- Cultural norms on sexuality differ between cultures and over time
- Respect for the diversity of views and beliefs about sexuality
- Cultural norms and taboos about sexuality
- Impact of culture and law in determining what is considered acceptable and unacceptable sexual behaviour in the society
- Culture, law and traditional practices affect the rights and equality of girls and women
- Sexual and reproductive rights as articulated in international instruments
- Laws governing sexual and reproductive health (e.g. child marriage, female genital cutting (FGC), age of consent, abortion, sexual orientation, rights of young people to SRH services, etc.)
- Gender equality as a human right

## Key Concept 3

### – Culture, Society and Law

#### 3.2 Sexuality and the Media

##### Learning Objectives for Level I (5-8)

*Identify different forms of media*

*Distinguish between examples from reality and fiction (e.g. television, internet)*

##### Key Idea:

- Different mass media are positive and negative in their representation of people

##### Learning Objectives for Level II (9-12)

*Identify examples of how men and women are portrayed in the mass media*

*Describe the impact of mass media upon personal values, attitudes and behaviour relating to sex and gender*

##### Key Ideas:

- Mass media influences on social norms concerning gender, sexual and reproductive health
- Mass media messages about sexuality

##### Learning Objectives for Level III (12-15)

*Identify unrealistic images in the mass media concerning sexual relationships, sexuality and reproduction*

*Describe the impact of these images on gender stereotyping*

##### Key Ideas:

- Influence of mass media on values and attitudes
- Mass media representations of beauty and gender stereotypes
- Self-esteem and how the mass media portrays men and women
- Gender stereotyping in pornography

##### Learning Objectives for Level IV (15-18)

*Critically assess the potential influence of mass media messages about sex, gender and sexuality on sexual behaviour and risk-taking*

*Identify ways in which the mass media could make a positive contribution to promoting safer sexual activity and gender equality*

##### Key Ideas:

- Importance of critical reading of mass media
- Challenging negative or inaccurate mass media messages

### 3.3 The Social Construction of Gender

#### Learning Objectives for Level I (5-8)

##### *Define gender*

##### **Key Ideas:**

- Gender roles and gender bias
- Examples of gender stereotypes
- Gender inequality

#### Learning Objectives for Level II (9-12)

##### *Identify specific ways in which gender inequality affects boys and girls, women and men*

##### **Key Ideas:**

- Overcoming gender bias and inequality
- Gender rights
- Families, schools, friends, media and society as sources of messages about gender
- Examples of gender inequality
- Gender role similarities and differences
- Factors that influence gender roles

#### Learning Objectives for Level III (12-15)

##### *Explain the meaning of and provide examples of gender bias and discrimination*

##### **Key Ideas:**

- Personal values regarding gender equality and bias
- The impact of social, cultural and religious norms about gender on people's behaviour
- Impact of gender role expectations on sexual behaviour
- Impact of gender roles on common decision-making in sexual behaviour and family planning
- Gendered 'double standards', including sexual behaviour

#### Learning Objectives for Level IV (15-18)

##### *Identify personal examples of the ways in which gender affects people's lives*

##### **Key Ideas:**

- Rigid gender roles can reinforce behaviour that increases the risk of sexual coercion, abuse and violence
- Personal values about gender roles and gender equality
- Equal decision-making in matters related to sexual activity and family planning
- Strategies for promoting gender equality and reducing gender bias



# Key Concept 3

## – Culture, Society and Law

### 3.4 Gender-Based Violence, Sexual Abuse, and Harmful Traditional Practices

#### Learning Objectives for Level I (5-8)

*Describe examples of positive and harmful practices*

*Describe the concept of gender*

#### Key Ideas:

- How harmful cultural/traditional practices affect health and well-being
- Gender roles, stereotypes and gender-based violence
- Definition of gender inequality
- Male/son preference and culture
- Concepts of body rights and sexual abuse
- Difference between consensual sexual activity and forced sex

#### Learning Objectives for Level II (9-12)

*Explain how gender role stereotypes contribute to forced sexual activity and sexual abuse*

*Define and describe gender-based violence, including rape and its prevention*

*Demonstrate relevant communication skills (e.g. assertiveness, refusal) in resisting gender discrimination and sexual harm*

#### Key Ideas:

- What to do if someone is sexually abused or raped
- Positive traditional beliefs and practices
- Examples of harmful traditional practices (e.g. male/son preference, nutritional taboos, FGC, child marriage, honour killings, bride killings, polygamy, double standards regarding gender roles and sexual behaviour)
- Preventing/minimising harmful traditional practices
- Relationship between gender-based violence, sexual abuse, and harmful traditional practices and STIs including HIV and unintended pregnancy
- Legality of harmful traditional practices and implications on gender equality and health

#### Learning Objectives for Level III (12-15)

*Identify specific strategies for reducing gender-based violence, including rape and sexual abuse*

*Demonstrate assertive communication skills in responding to situations of potential sexual harm*

#### Key Idea:

- Eliminating harmful traditional practices such as FGC, child marriage, forced marriage, etc
- Recognising and responding to gender-based violence and know where to find help

#### Learning Objectives for Level IV (15-18)

*Demonstrate ability to argue for the elimination of gender role stereotypes and inequality, harmful traditional practices and gender-biased violence*

#### Key Ideas:

- Advocacy to promote equality and human rights
- Personal responsibility to stand up and speak out against social injustices such as gender inequality, harmful traditional practices and gender-based violence
- Advocacy to promote the right to and access to safe abortion

# Key Concept 4

## – Human Development

### 4.1 Sexual and Reproductive Anatomy and Physiology

#### Learning Objective for Level 1 (5-8)

##### *Distinguish between male and female bodies*

##### Key Ideas:

- Appropriate names for body parts and their functions
- Differentiate between male and female sexual organs
- Girls and boys have private body parts that can feel pleasurable when touched by oneself
- Appropriate public behaviour concerning private body parts
- Nakedness and shame

#### Learning Objectives for Level II (9-12)

##### *Describe the structure and function of the sexual and reproductive organs*

##### Key Ideas:

- Basic principles of sexual and reproductive anatomy and physiology, including the menstrual cycle, spermatogenesis and erection, wet dreams and ejaculation
- Both men and women can give and receive sexual pleasure
- Describe common genital problems

#### Learning Objectives for Level III (12-15)

##### *Distinguish between the biological and social aspects of sex and gender*

##### Key Ideas:

- Role of chromosomes in determining the sex of the foetus
- Sexual differentiation during pre-natal development
- Role of hormones in growth, development, and regulation of reproductive and sexual functioning
- Differences between the sexual response and reproductive systems
- Cultural, traditional and religious practices relating to sex, gender, puberty and reproduction (including male circumcision and FGC)
- Nature and impact of social and cultural beliefs about sex and gender e.g. virginity.

#### Learning Objectives for Level IV (15-18)

##### *Describe the sexual and reproductive capacity of males and females over the life cycle*

##### Key Ideas:

- Changes in hormones, reproductive capacity and sexual functioning across the lifecycle
- Men and women can experience giving and receiving sexual pleasure throughout life

# Key Concept 4

## – Human Development

### 4.2 Reproduction

#### Learning Objectives for Level I (5-8)

*Describe where babies come from*

##### Key Ideas:

- Reproduction requires a sperm and an egg
- Basic processes of fertilisation, conception, delivery and pregnancy

#### Learning Objectives for Level II (9-12)

*Describe both how pregnancy occurs and how it can be prevented*

##### Identify basic contraceptive methods

##### Key Ideas:

- Relationship between vaginal intercourse and pregnancy
- Specific means of preventing unintended pregnancy
- Correct and consistent use of condoms and contraception prevent pregnancy, HIV and other STIs
- Ovulation and when conception is most likely and least likely to occur
- Relationship between excitement and vaginal lubrication, penile erection and ejaculation
- Health risks of early marriage (voluntary and forced), early pregnancy and birth
- Health issues and risks of poor nutrition, smoking and using alcohol and drugs during pregnancy
- Health issues and risks involved in being pregnant and HIV-positive

#### Learning Objectives for Level III (12-15)

*Describe the signs of pregnancy, and the stages of foetal development and childbirth*

*Describe the correct and consistent use of different methods of contraception in preventing unintended pregnancy*

##### Key Ideas:

- Health risks of early pregnancy
- Effectiveness rates of the different methods of contraception
- Definition, reasons for, and legality of abortion
- Health risks associated respectively with safe and legal abortion, and with illegal and unsafe abortion

#### Learning Objectives for Level IV (15-18)

*Differentiate between reproductive and sexual function and desires*

##### Key Ideas:

- Sexual activity can provide pleasure
- Sexual activity should only occur when there is mutual consent
- Prevention (of unintended pregnancy and sexually transmitted infection) needs to be considered beforehand
- Menopause and male climacteric in relation to reproductive function
- Infertility and fertility treatment options

## 4.3 Puberty

### Learning Objectives for Level I (5-8)

*Describe how bodies change as people grow*

*Describe the key features of puberty*

#### Key Idea:

- Puberty is a time of physical and emotional change that happens as children grow and mature

### Learning Objectives for Level II (9-12)

*Describe the process of puberty and the maturation of the sexual and reproductive system*

#### Key Ideas:

- Range of social, emotional and physical changes associated with puberty
- Importance of good hygiene as the body matures (e.g. washing the genitals, menstrual hygiene, etc.)
- Access and proper use of sanitary pads and other menstrual aids
- How puberty relates to reproductive capability
- Wet dreams

### Learning Objectives for Level III (12-15)

*Describe the similarities and differences between girls and boys in relation to the physical, emotional, and social changes associated with puberty*

*Distinguish between puberty and adolescence*

#### Key Ideas:

- Some people do not reach full puberty until the mid or late teens
- Pleasurable sexual thoughts and feelings are part of pubertal development
- Pleasurable sexual feelings and thoughts can be enjoyed without acting upon them

### Learning Objectives for Level IV (15-18)

*Describe the key emotional and physical changes in puberty that occur as a result of hormonal changes*

#### Key Ideas:

- Specific role and function of male and female hormones on emotional and physical changes
- Hormones involved in ovulation and the menstrual cycle
- Role of hormones in spermatogenesis
- Dealing with physical and emotional changes

# Key Concept 4

## – Human Development

### 4.4 Body Image

#### Learning Objectives for Level I (5-8)

*Recognise that bodies are all different*

##### Key Ideas:

- All bodies (including those with disabilities) are special and unique
- Everyone can be proud of their body

#### Learning Objectives for Level II (9-12)

*Differentiate between cultural ideals and reality in relation to physical appearance*

##### Key Ideas:

- Physical appearance is determined by heredity, environment and health habits
- Mass media images of our bodies and how they affect how people feel about their bodies and themselves
- Most people do not conform to stereotypical images of beauty
- A person's value should not be determined by their appearance
- Ideals of physical attractiveness change over time and between cultures

#### Learning Objectives for Level III (12-15)

*Describe how peoples' feelings about their bodies can affect their health, self- image and behaviour*

##### Key Ideas:

- The size and shape of the penis, vulva or breasts vary and do not affect reproduction or the ability to be a good sexual partner
- The appearance of a person's body can affect how other people feel about and behave towards them
- Harm associated with taking drugs in order to conform to unrealistic, gendered standards of beauty
- Harm associated with eating disorders e.g. anorexia and bulimia

#### Learning Objectives for Level IV (15-18)

*Identify particular culture and gender role stereotypes and how they can affect people and their relationships*

##### Key Ideas:

- Critically assessing unrealistic standards regarding bodily appearance
- Understanding the impact of plastic surgery
- Physical appearance is only one factor involved in personal attraction
- Body image can affect self-esteem, decision-making and behaviour

## 4.5 Body Rights

### Learning Objectives for Level I (5-8)

*Describe the meaning of 'body rights'*

#### Key Ideas:

- The right to decide who can touch my body, where, and in what way
- Difference between "public" and "private" body parts and between appropriate and inappropriate touch
- Saying "no" and refusing inappropriate or unwanted touch or behaviour
- Bullying and what to do about it
- Knowing where to ask for help if inappropriately touched
- Knowing that sexual abuse in the family is always wrong

### Learning Objectives for Level II (9-12)

*Define unwanted sexual attention*

*Demonstrate ways of resisting unwanted sexual attention*

#### Key Ideas:

- Right to refuse unwanted sexual attention
- What to do and where to go for help
- Bullying (including phone and cyber-bullying)
- Dealing with pressure to have sex
- Defining sexual harassment and coercive sex, including rape
- Avoiding and responding to sexual harassment and coercion

### Learning Objectives for Level III (12-15)

*Identify key elements of keeping oneself safe from sexual harm*

#### Key Ideas:

- Exercising body rights
- The importance of being in control over what we will and will not do sexually
- Risks associated with the internet e.g. unwanted sexual attention, phone- and cyber-bullying
- Risks associated with transactional and transgenerational sexual encounters

### Learning Objectives for Level IV (15-18)

*Describe some ways in which society, culture, law and gender roles can affect social interactions and sexual behaviour*

#### Key Ideas:

- Double standards of sexual behaviour and impact on social and sexual interactions
- Relationship between gender role stereotypes and sexual violence
- Role of gender equality in preventing gender-based violence

# Key Concept 5

## – Sexual Behaviour

### 5.1 Sex, Sexuality and the Sexual Life Cycle

#### Learning Objectives for Level I (5-8)

*Explain the concept of private parts of the body*

##### Key Ideas:

- Most children are curious about their bodies
- It is natural to explore and touch parts of one's own body
- Bodies can feel good when touched
- Touching and rubbing one's genitals is called masturbation
- Some people masturbate and some do not
- Masturbation is not harmful, but should be done in private

#### Learning Objectives for Level II (9-12)

*Describe sexuality in relation to the human life cycle*

##### Key Ideas:

- Human beings are born with the capacity of enjoying their sexuality
- Masturbation is often a person's first experience of sexual pleasure
- Many boys and girls begin to masturbate during puberty
- Masturbation does not cause physical or emotional harm
- People in long-term relationships may still masturbate
- Most young people are curious about sexuality and have many questions
- It is acceptable to talk and ask questions about sexuality
- Definitions of sex, sexuality, gender, gender role, gender identity, and sexual orientation
- Cultural and gender role stereotypes affect sexual behaviour
- Importance of talking with trusted adult about sexuality

#### Learning Objectives for Level III (12-15)

*Explain ways in which sexuality is expressed across the life cycle*

##### Key Ideas:

- Respect for the different sexual orientations and gender identity
- People do not choose their sexual orientation or gender identity
- Tolerance and respect for the different ways sexuality is expressed locally and across cultures
- Masturbation is a safe and valid expression of sexuality
- Sexual feelings, fantasies and desires are natural and occur throughout life
- People do not have to act upon their sexual thoughts, fantasies and feelings and are able to control them when needed

#### Learning Objectives for Level IV (15-18)

*Define sexuality in relation to its biological, social, psychological, spiritual, ethical and cultural components.*

##### Key Ideas:

- The concept of sexuality is complex and multi-faceted
- Sexuality can enhance well-being when expressed respectfully
- Interest in sexuality may change with age
- People can remain sexually active into old age



## 5.2 Shared Sexual Behaviours and Sexual Response

### Learning Objectives for Level I (5-8)

*Explain that sexual activity is a mature way of showing care and affection*

#### Key Ideas:

- Bodies can feel good when touched
- Adults show love and care for other people in different ways, including sometimes through sex
- People kiss, hug, touch, and engage in sexual behaviours with one another to show care, love, physical intimacy and to feel good
- Children are not ready for sexual contact with other people

### Learning Objectives for Level II (9-12)

*Describe male and female response to sexual stimulation*

#### Key Ideas:

- Sexual stimulation (physical or mental) produces physical responses
- During puberty, boys and girls become more aware of their responses to sexual attraction and stimulation
- Showing love involves more than penetrative sex
- There are a range of ways in which couples can demonstrate love, care, and feelings of sexually attraction
- Sexual relationships require emotional and physical maturity
- Understand that human beings have a natural physical response to sexual stimulation
- People can have sexual thoughts and feelings without acting on them and are able to control them when needed
- The components of the male and female human sexual response cycle
- Definition and function of orgasm
- Concept, examples and positive and negative effects of 'aphrodisiacs'
- Advantages and disadvantages of sexual information and imagery obtained from the internet
- Dangers of forming sexual relationships over the internet
- Skills in using the internet for making friends
- Avoiding unwanted sexual attention on the internet
- Few, if any people, have a sexual life that is without problems or disappointments

# Key Concept 5

## – Sexual Behaviour

### 5.2 Shared Sexual Behaviours and Sexual Response (contd.)

#### Learning Objectives for Level III (12-15)

##### *Describe common sexual behaviours*

##### *Describe the key elements of the sexual response cycle*

##### **Key Ideas:**

- People give and receive sexual pleasure to express their love and feelings
- A person has the right to refuse unwanted sexual contact
- Abstinence means choosing not to engage in sexual behaviours with others
- Contraceptives and condoms give people the opportunity to enjoy their sexuality without unintended consequences
- There are many ways to give and receive sexual pleasure without penetration
- Definition and description of the physical changes and stages of male and female human sexual response, including orgasm
- Common myths about sex
- People differ in their sexual identity and orientation and gender identity
- Influences on sexual beliefs and practice
- Personalising sexual risks
- Sexual behaviours include kissing, touching, talking, caressing, oral intercourse and penetration
- It is harmful to pressure another person to engage in any sexual behaviour
- Defining and refusing transactional sex
- Both men and women can give and receive sexual pleasure with a partner of the same or opposite sex

#### Learning Objectives for Level IV (15-18)

##### *Define key elements of sexual pleasure and responsibility*

##### **Key ideas:**

- Good communication can enhance a sexual relationship
- Sexual behaviours can be pleasurable and without risk of unintended pregnancy and STIs including HIV
- Everyone is responsible for their own and their partner's sexual pleasure and can learn to communicate their likes and dislikes
- Everyone is responsible for preventing unintended pregnancy and STIs including HIV
- Many adults have periods in their lives without sexual contact with others

# Key Concept 6

## – Sexual and Reproductive Health

### 6.1 Pregnancy Prevention

#### Learning Objectives for Level I (5-8)

*Recognise that not all couples have children*

#### Key Ideas:

- Children should be wanted, cared for, and loved
- Some people are unable to care for a child
- All people regardless of their health status, religion, origin, race or sexual status can raise a child and give it the love it deserves

#### Learning Objectives for Level II (9-12)

*Describe key features of pregnancy and contraception*

#### Key Ideas:

- Signs and symptoms of pregnancy
- Not having sexual intercourse is the most effective form of contraception
- Condoms and other contraceptives (including emergency contraception) can be used to prevent unintended pregnancy
- Correct and consistent use of condoms can prevent unintended pregnancy, HIV and other STIs
- Myths and facts about condoms, contraceptives and other ways to prevent unintended pregnancy
- Children should not have penetrative sexual intercourse
- Ways of avoiding unintended pregnancy
- Natural contraceptive methods are only safe for adults
- Respective responsibilities of men and women to use condoms and contraceptives
- Health and social consequences of early unintended pregnancy
- Options available to teenagers who are unintentionally pregnant
- Definition of abortion
- Legal status of abortion locally and globally
- Legal abortion performed under sterile conditions by medically trained personnel is safe
- Health risks of illegal and unsafe abortion
- Key characteristics of condoms
- Steps for proper use of condoms
- Refusal skills to avoid unwanted sex

# Key Concept 6

## – Sexual and Reproductive Health

### 6.1 Pregnancy Prevention (contd.)

#### Learning Objectives for Level III (12-15)

*Describe effective methods of preventing unintended pregnancy and their associated efficacy*

*Explain the concept of personal vulnerability to unintended pregnancy*

#### Key Ideas:

- Regardless of their marital status, sexually active young people have the right to access contraceptives and condoms
- Obtaining and using condoms and contraceptives (including emergency contraception where legal and available)
- Overcoming barriers to obtaining and using condoms and contraception
- Identify local sources of condoms and contraceptives
- Use and misuse of emergency contraception
- Consistent and correct use of condoms and contraceptives
- Role of gender in accessing condoms and contraceptives
- Access to safe abortion and post-abortion care

#### Learning Objectives for Level IV (15-18)

*Describe personal benefits and possible risks of available methods of contraception*

*Demonstrate confidence in discussing and using different contraceptive methods*

#### Key Ideas:

- Sterilisation is a permanent method of contraception
- Difference between efficacy and effectiveness of contraceptive methods
- Importance of correct and consistent use of contraception, including emergency contraception and condoms
- Side effects and contra-indications of specific contraceptive methods
- Impact of peer norms on the use of condoms and contraceptives and sexual risk-taking behaviour
- Obtaining condoms and contraceptives in the local community
- Importance of family planning for individuals, families and society
- Impact of gender expectations on the use of family planning
- Choosing the most appropriate method of contraceptives
- Access to safe abortion and post-abortion care

## 6.2 Understanding, Recognising and Reducing Risk of STIs including HIV

### Learning Objective for Level I (5-8)

*Describe the concepts of 'health' and 'disease'*

#### Key Ideas:

- How some diseases are transmitted from one person to another
- Staying healthy
- The immune system and how it protects the body from diseases
- HIV and AIDS and how they affect the immune system
- How HIV and other STIs are spread
- People living with HIV need love, care and support
- You cannot tell by looking if a person has HIV
- How someone who has HIV can and can not pass the virus on to other people
- Impact of HIV and AIDS on the community
- We can help each other make healthy choices
- Knowing where to ask for help when we are sick

### Learning Objectives for Level II (9-12)

*Explain how STIs and HIV are transmitted, treated and prevented*

*Demonstrate communication skills as they relate to safer sex*

#### Key Ideas:

- Myths and facts about penetrative sexual intercourse
- Safe alternatives to sexual intercourse and reasons for avoiding penetrative sex
- Myths and facts about STIs and HIV and AIDS
- Biology of HIV and STI infection
- Treatments for HIV and AIDS and their side effects
- Post Exposure Prophylaxis (PEP) for HIV
- Define safer sex
- Risk reduction for STI and HIV
- Ways in which culture, gender and peers can influence sexual behaviour
- Young people living positively with HIV and AIDS
- Partner notification
- Transmission of HIV from mother to baby
- Minimising the risk of mother to child transmission of HIV
- Transmission of HIV through unsterilized equipment, including injecting drugs

# Key Concept 6

## – Sexual and Reproductive Health

### 6.2 Understanding, Recognising and Reducing Risk of STIs including HIV (contd.)

#### Learning Objectives for Level III (12-15)

*Identify specific ways of reducing the risk of acquiring or transmitting HIV and other STIs including the correct use of condoms*

*Explain how culture and gender affect personal decision-making regarding sexual relationships*

*Describe the physical, emotional, and social impact of living with HIV*

*Demonstrate skills in negotiating safer sexual intercourse and refusing unsafe sexual practices*

#### Key Ideas:

- Reasons for delaying sexual intercourse
- Visiting sexual health services, including voluntary counselling and testing (VCT) centres, in the community
- Importance of positive attitudes towards condom use and risk reduction
- Risk associated with multiple and with concurrent partnerships
- Risks of intergenerational relationships
- Partner notification and STIs, HIV and AIDS
- Effects of culture and gender on partner communication about sexual health
- Self-efficacy and vulnerability
- Negotiating safer sexual practices
- Strengthening intention to consistently use condoms
- Perceptions of peer norms about penetrative and safer sexual intercourse
- PEP for HIV
- Personalising sexual risk assessment
- The vast majority of HIV infections are transmitted through unprotected penetrative sexual intercourse with an infected partner
- Not having sexual intercourse is the most effective protection against STIs, HIV and unintended pregnancy

#### Learning Objectives for Level III (12-15)

#### Key Ideas continued:

- Correct and consistent use of condoms can reduce risk of STIs including HIV
- Alcohol and drug use increase risks for engaging in high-risk behaviours
- Assessing personal risks and perceived vulnerability
- 'Mutual monogamy'
- Protected sexual practices
- Alternative and safer sexual practices
- Importance of exploring one's own attitude about safer sexual practices
- Stigma and discrimination toward people living with HIV
- Schools and community resources to educate students and their families about HIV and AIDS
- One's role and responsibility to educate one's peers about STI/HIV prevention

#### Learning Objectives for Level IV (15-18)

*Assess a range of risk reduction strategies for effectiveness and personal preference*

*Demonstrate communication and decision-making skills in relation to safer sexual intercourse*

#### Key Ideas:

- Key factors that make it difficult for people to practice safer sexual intercourse and ways of responding to these
- How gender role stereotypes can increase risk for HIV and other STIs
- Possible consequences of having penetrative sexual intercourse
- Benefits of dual protection (condoms and contraception)
- Strategies for addressing these
- Attitudes towards people living with HIV

## 6.3 HIV and AIDS Stigma, Treatment, Care and Support

### Learning Objectives for Level I (5-8)

*Identify the basic needs of people living with HIV*

#### Key Ideas:

- All people need love and affection
- People living with HIV can give love and affection and can contribute to their environment and society
- People living with HIV have rights and deserve love, respect, care and support
- There are medical treatments that help people live positively with HIV
- How HIV and AIDS affect individuals, families, and communities

### Learning Objectives for Level II (9-12)

*Describe the emotional, economic, physical and social challenges of living with HIV*

#### Key Ideas:

- Need for positive attitudes, care, and respect towards people living with HIV
- HIV and AIDS affect family structure, family roles, and responsibilities
- Key emotional, health, nutritional and physical needs of orphans and other vulnerable children
- ART and side-effects on puberty
- The importance of getting tested for HIV
- Stigma, self-stigma and discrimination

### Learning Objectives for Level III (12-15)

*Explain the importance and key elements of living positively with HIV*

#### Key Ideas:

- Stigmatisation and discrimination against people living with HIV
- Key aspects of HIV treatment
- Where and how to access voluntary HIV counselling and testing
- The technicalities of disclosing one's HIV status
- People living with HIV have a right to sexuality education and to express their love and feelings via sexuality
- People living with HIV have the right to marry and start a family

### Learning Objectives for Level IV (15-18)

*Describe the concept and causes of stigma and discrimination in relation to people living with HIV*

*Describe key social, economic, and health issues associated with living with HIV*

#### Key Ideas:

- Effects of HIV-related stigma and discrimination on individuals and communities
- Strategies for challenging stigma and discrimination
- ART
- Nutritional needs for people living with HIV
- Care and support for people living with HIV
- Death, grief and loss
- Advocacy for the rights of people living with HIV



# Endnotes

1. UNAIDS. 2006. *Scaling up access to HIV prevention, treatment, care and support. The next steps*. Geneva: UNAIDS.
2. These included but were not limited to the following sites: SIECUS; Johns Hopkins Bloomberg School of Public Health Center for Communications Program's The Info Project; International HIV/AIDS Alliance; Family Health International; Institute of Education, University of London; United Nations Educational, Scientific and Cultural Organization (UNESCO); UNESCO International Bureau of Education (IBE); United Nations Population Fund (UNFPA); and International Planned Parenthood Federation (IPPF).
3. Botswana, Ethiopia, Indonesia, Jamaica, Kenya, Namibia, Nigeria, South Africa, Tanzania, Thailand, USA, Zambia.
4. WHO. 2002. *Defining sexual health: report of a technical consultation on sexual health*. Geneva: WHO
5. Stirling, M., Rees, H., Kasedde, S., Hankins, C. 2008. *Addressing the vulnerability of young women and girls to stop the HIV epidemic in southern Africa*. Geneva: UNAIDS.
6. Birungi, H., Mugisha, J.F. and Nyombi, J.K. 2007. *Sexuality of young people perinatally infected with HIV: A neglected element in HIV/AIDS Programming in Uganda*. Exchange on HIV/AIDS, sexuality and gender. Nairobi: Population Council.
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8. Delors, J., Al Mufti, I., Amagi, I., Carneiro, R. et al. 1998. *Learning: the treasure within. Report to UNESCO of the International Commission on Education for the Twenty-first Century*. Paris: UNESCO.
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10. WHO and UNICEF. 2003. *Skills for Health: Skills-based health education including life skills*. Geneva: WHO and UNICEF.
11. UNESCO. 2008. *School-centered HIV & AIDS Care and Support*. Paris: UNESCO.
12. See appendix VIII: Hubbard, Giese and Rainey, 1998; Jemmott, Jemmott, Braverman and Fong, 2005; St. Lawrence, Crosby, Brasfield and O'Bannon, 2002; St. Lawrence et al., 1995; Zimmerman et al., 2008; Zimmerman et al., forthcoming.
13. See appendix VIII: Borawski, Trapl, Lovegreen, Colabianchi and Block, 2005; Clark, Trenholm, Devaney, Wheeler and Quay, 2007; Denny and Young, 2006; Kirby, Korpi, Barth and Cagampang, 1997; Rue and Weed, 2005; Trenholm et al., 2007; Weed et al., 1992; Weed et al., 2008.
14. Kirby et al. 2007. *Tool to Assess the 17 Characteristics of Effective Sex and STD/HIV Education Programmes*. Washington, DC: Healthy Teen Network.
15. Kirby, D., Laris, B. and Roller, L. 2005. *Impact of Sex and HIV Curriculum-based Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries*. Washington DC: Family Health International.
16. Baral, S., Trapence, G., Motimedi, F., Umar, E. et al. 2008. *HIV Prevalence, Risks for HIV Infection, and Human Rights among Men Who Have Sex with Men (MSM) in Malawi, Namibia, and Botswana*. PLoS ONE 4(3): e4997. doi:10.1371/journal.pone.0004997
17. WHO and UNAIDS. 2009. *Operational guidance for scaling up male circumcision services for HIV prevention*. Geneva: WHO.
18. Abortion is illegal or severely restricted in some of UNESCO's Member States.

# **Part III:**

## **Appendices**

**Conference Ready Version**

# Appendix I

## Glossary on sex and sexuality terms

Many of the definitions used in this glossary have been developed and modified from other sources including *Talk About Sex* (SIECUS, 2005 [http://www.siecus.org/\\_data/global/images/TalkAboutSex.pdf](http://www.siecus.org/_data/global/images/TalkAboutSex.pdf)), the International Planned Parenthood Federation's online Glossary of Sexual and Reproductive Health Terms (see <http://glossary.ippf.org/GlossaryBrowser.aspx>) and WHO's *Defining Sexual Health: report of a technical consultation on sexual health* (2006, see [http://www.who.int/reproductive\\_health/publications/sexualhealth/index.html](http://www.who.int/reproductive_health/publications/sexualhealth/index.html)).

**Abstinence:** Sexual abstinence is a conscious decision to avoid certain sexual activities or behaviours. Different people have different definitions of sexual abstinence. For some, it may mean no sexual contact. For others, it may mean no penetration (oral, anal, vaginal) or only 'lower-risk' behaviours such as safer sex where no body fluids are exchanged between partners. People of all ages, genders, and sexual orientations can choose to be abstinent at any time in their lives.

**Abstinence-only Education:** (e.g. Abstinence-only; Abstinence-only-until-marriage): These are programmes that emphasise abstinence from all sexual behaviours. These programmes do not include information about contraception or disease prevention methods. Abstinence-only-until-marriage education emphasises abstinence from all sexual behaviours outside of marriage. If contraception or disease-prevention methods are discussed, these programmes typically emphasise failure rates. In addition, they often present marriage as the only morally correct context for sexual activity. Fear-based programmes include abstinence-only and abstinence-only-until-marriage programmes that are designed to control young people's sexual behaviour by instilling fear, shame and guilt. These programmes often rely on negative messages about sexuality, distort information about condoms and STIs, and may promote biases based on gender, sexual orientation, marriage, family structure, and pregnancy options. Abstinence education promotes abstinence

from all forms of sexual activity until marriage, and abstinence as the only way in which HIV infections and unwanted pregnancies can be prevented. This type of education often does not discuss issues relating to contraception, sexuality or sexual and reproductive health issues, which are typically included in comprehensive sexuality education programmes. It should be noted that abstinence is often taught as one option for safer sex as part of comprehensive sexuality education programmes.

**Gender:** Gender refers to the economic, social and cultural attributes associated with being male or female in a particular point in time (WHO 2001). It may also refer to a person's biological, social, or legal status as male or female.

**Gender Equality:** Equal representation of women and men. Gender equality does not imply that women and men are the same, but that they have equal value and should be accorded equal treatment.

**Gender Roles:** A person's outward expression of who they are as males or females, which is often based on the prevalent cultural and social norms about what is acceptable feminine or masculine roles and behaviour.

**Reproductive Rights:** The definition of reproductive rights agreed at the International Conference on Population and Development, stated: "*Reproductive rights... rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents... The promotion of... these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning.*"

**Sex\*:** Sex refers to the biological characteristics that define humans as female or male. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean ‘sexual activity’, but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.

**Sexuality\*:** Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

**Sexuality Education:** An age-appropriate, culturally sensitive and comprehensive approach to sexuality education that include programmes providing scientifically accurate, realistic, non-judgmental information. Comprehensive sexuality education provides opportunities to explore one’s own values and attitudes and to build decision-making, communication and risk reduction skills about all aspects of sexuality. Comprehensive sexuality education promotes critical thinking, self-actualisation, and behavioural change through gaining knowledge about the body; healthy sexuality; relationships; sex abuse, pregnancy, HIV and sexually transmitted infection prevention; and many other topics regarding human sexuality, and sexual and reproductive health and rights. A comprehensive sexuality programme will respect the diversity of values and beliefs represented in the community and will complement and augment the sexuality education children receive from their families, religious and community groups, and health care professionals.

**Sexual and Reproductive Health Services:** Defined as the methods, techniques and services that contribute to sexual and reproductive health and well-being through preventing and solving reproductive health problems. All people have a right to information, education, and health care services that promote, maintain, and restore sexual and reproductive health.

**Sexual Health\*:** Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease,

dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

**Sexual Intercourse:** Penetrative sexual behaviours, including oral sex, anal sex and penile-vaginal sex.

**Sexual Rights\*:** Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

**Sexual orientation:** Sexual orientation refers to the sex and/or gender of another person to which a person finds themselves emotionally and sexually attracted. The common terms for the variety of sexual orientations are homosexual, gay, lesbian, bisexual, transgender, questioning and heterosexual. Some individuals may identify themselves as asexual, and others as other. For example, a man who becomes a woman and is attracted to other women would be identified as a

\* These working definitions were developed through a consultative process with international experts beginning with the WHO Technical Consultation on Sexual Health in January 2002. They reflect an evolving understanding of the concepts and build on international consensus documents such as the International Conference on Population and Development (ICPD) Programme of Action and the Beijing Platform for Action. These working definitions are offered as a contribution to advancing understanding in the field of sexual health. They do not represent an official position of WHO.

lesbian. Adapted from <http://www.gaycenter.org/gip/transbasics/faq/>

**Gay:** describes a man who is sexually and emotionally attracted to other men. Source: <http://www.glaad.org/>

**Lesbian:** describes a woman who is sexually and emotionally attracted to other women. Source: <http://www.glaad.org/>

**Bisexual:** is an individual who is sexually and emotionally attracted to men and women. Bisexual people need not have had a sexual experience at all to identify as bisexual. Source: <http://www.glaad.org/>

**Transgender:** is a broad term, generally used to include any person who feels their assigned sex does not completely or adequately reflect their internal gender identity. This includes the group of all people who are inclined to cross gender lines, including transsexuals, cross-dressers and other gender non-conforming individuals. This is the main reason why we say the term transgender is an “umbrella” term, as it covers a wide array of individuals. Few people also use the word transgender as a synonym for transsexual, however, transgender people may or may not take steps to live as a different gender. Source: <http://www.glaad.org/>

**Questioning:** describes people who are in the process of identifying their sexual identity. Source: <http://www.glaad.org/>

**Homosexual:** is an individual who is sexually and emotionally attracted to a person of the same sex. Homosexual people need not have had a sexual experience at all to identify as homosexual.

**Heterosexual:** is an individual who is sexually and emotionally attracted to a person of the opposite sex. Heterosexual people need not have had a sexual experience at all to identify as heterosexual.

# Appendix II

## International conventions outlining the entitlement to sexuality education

Sexuality education is critical to reducing unplanned pregnancies, unsafe abortion, and prevention of HIV and STI among young people. The globally recognised Platforms of Actions developed at the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing underscore the obligations in international law for states to provide sexuality education in primary and secondary schools. A variety of international authorities, such as UN Treaty Monitoring Committees, have also set standards on topics that should be included, and unanimously support that sexuality education programmes in schools must be comprehensive, covering topics of pregnancy, unsafe abortion, the prevention of HIV and STI, family planning and contraception.<sup>1</sup>

Some international organizations also support the view that governments are obligated to provide sexuality education in school. The International Planned Parenthood Federation's (IPPF's) declaration in 2008 argued that governments are obligated to guarantee sexual rights, and that sexuality education is an integral component of human rights.

In these *International Guidelines* the entitlement to sexuality education is interpreted from the standpoint that children and young people have a specific need for information and skills on sexuality education that makes a difference to their life chances. The threat to life and their well-being exists in a range of contexts, whether it is in the form of abusive relationships, exposure to HIV or stigma and discrimination because of their sexual orientation. Given the complexity of the task facing any teacher or parent in guiding and supporting the process of learning and growth, it is crucial to strike the right balance between the need to know and what is age-appropriate and relevant.

<sup>1</sup> Centre for Reproductive Rights. 2008. *An International Human Right: Sexuality Education for Adolescents in Schools*. New York: Center for Reproductive Rights.

For decision-makers concerned with setting policy on sexuality education, a report by the Center for Reproductive Rights (CRR), *An International Human Right: Sexuality Education for Adolescents in Schools*, succinctly outlines the mandates from Platforms of Action, Treaties, and global consensus documents that call on States to provide sexuality education in schools. The CRR report provides several examples:

- The 1994 ICPD **Programme of Action** recognises that education about sexual and reproductive health must begin in primary school and continue through all levels of formal and non-formal education to be effective.<sup>2</sup>
- The Joint United Nations Programme on HIV/AIDS (UNAIDS) has concluded that the most effective approaches to sexuality education begin with educating young people before the onset of sexual activity.<sup>34</sup> UNAIDS recommends that HIV prevention programmes should be comprehensive, high quality and evidence-based; promote gender equality and address gender norms and relations; and include accurate and explicit information about safer sex, including correct and consistent male and female condom use.<sup>4</sup>
- The World Health Organization (WHO) concludes it is critical that sexuality education be started early, particularly in developing countries, because girls in the first classes of secondary school face the greatest risk of the consequences of sexual activity, and beginning sexuality education in primary school also reaches students who are unable to

<sup>2</sup> ICPD *Programme of Action*, supra note 2, para. 11.9.

<sup>3</sup> UNAIDS. 1997. *Impact of HIV and Sexual Health on the Sexual Behaviour of Young People: A Review Update 27*. Geneva: UNAIDS.

<sup>4</sup> UNAIDS. 2005. *Intensifying HIV Prevention*, supra note 26, at 33. Geneva: UNAIDS.

attend secondary school.<sup>5</sup> Guidelines from the WHO Regional Office for Europe call on Member States to ensure that education on sexuality and reproduction is included in all secondary school curricula and is comprehensive.<sup>6</sup>

- EDUCAIDS, a UNAIDS initiative for a comprehensive education sector response to HIV and AIDS that is led by UNESCO, recommends that HIV and AIDS curricula in schools “begin early, before the onset of sexual activity”, “build knowledge and skills to adopt protective behaviours and reduce vulnerability”, and “address stigma and discrimination, gender inequality and other structural drivers of the epidemic”.<sup>7</sup>
- The Committee on the Rights of the Child (e.g., The Children’s Right Committee), in monitoring the 1989 Convention on the Rights of the Child (CRC), concludes that “the rights to health and information require states to provide children with adequate, appropriate and timely HIV and AIDS, and sexual health information”, and that parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.<sup>8</sup> The Committee also states that adolescents “have the right to access adequate information essential for their health and development”, and that States must ensure that “all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours”.<sup>9</sup> It further “recognises that the right to education requires provision of information necessary to develop a healthy lifestyle”, and recommends that states parties make sexuality education part of the official curricula for primary and secondary school.
- The Committee on the Elimination of Discrimination Against Women (CEDAW) urges states parties to make sexuality education compulsory, and to provide it systematically in schools, including vocational schools. CEDAW also requires that states parties eliminate all forms of gender stereotyping in

sex education programmes and curricula, including by revising textbooks and school programmes.<sup>10</sup>

The report, *Public Policy: A Tool to Promote Adolescent Sexual and Reproductive Health*, in *Promoting Adolescent Sexual and Reproductive Health in East and Southern Africa*, by the Nordiska Afrikainstitutet in Sweden also highlighted the following:

- The Programme of Action adopted at the Fourth World Conference on Women (Beijing, 1995) addresses many of the same adolescent sexual and reproductive (ASRH) issues as in the ICPD and the CRC documents. The Fourth World Conference on Women Platform of Action emphasises the need to remove barriers to education for women (particularly pregnant adolescents and young mothers); recognises that adolescents in many developing countries have limited access to comprehensive sexual and reproductive health information and services; encourages countries to promote mutually respectful and equitable gender relations; acknowledges that STIs and HIV are often consequences of sexual violence; and recognises that the rights of the child, and duties of parents must be addressed in adolescent health programmes.<sup>11</sup>
- International Platforms of Action continually call for improved adolescent sexual and reproductive health and rights; removal of barriers that impinge upon young people’s access to sexual and reproductive health information, programmes and services; and greater involvement of young people in the development of youth friendly programmes. The United Nations, with other bi-lateral and multi-national agencies, and Non-Governmental Organizations (NGOs) must work together to develop and implement policies and programmes that enhance the sexual and reproductive of the young people they serve.<sup>12</sup>

5 WHO. 2004. *Adolescent Pregnancy Report*. Geneva: WHO.

6 WHO. 2001. *WHO Regional Strategy on Sexual and Reproductive Health*. Copenhagen: WHO, Regional Office for Europe.

7 UNESCO. 2008. *EDUCAIDS Overviews*. Paris: UNESCO.

8 UN OHCHR. 2003. Convention on the rights of the Child, *General Comment 3*, *supra* note 23, para.16. Geneva: UN OHCHR.

9 UN OHCHR. 2003. Convention on the rights of the Child, *General Comment 4*, para. 26. Geneva: UN OHCHR.

10 CEDAW, *supra* note 39, at art. 10(c).

11 Pillay, Y. and Flisher, A., *Public Policy: A Tool to Promote Adolescent Sexual and Reproductive Health*, in *Promoting Adolescent Sexual and Reproductive Health in East and Southern Africa*, Nordiska Afrikainstitutet, Sweden, HSRC Press, Cape Town, 2008.

12 *Ibid*.



# Appendix III

## Interview schedule and methodology

The consultant interviewed key stakeholders/informants to document best practice with developing and implementing formal school-based sexuality education programmes and curricula in developing countries, particularly in sub-Saharan Africa. However, information about developing particularly innovative approaches existing in Europe and North America has also been included.

In general,

- A) Key informants were initially contacted by phone and/or email, and interviews were requested.
- B) Once they agreed to participate, and gave their informed consent, they were emailed a semi-structured interview guide so that they could prepare in advance, or choose to type up their responses.
- C) Arrangements were made to call the respondents at an agreed upon date and time, and
- D) Respondents were contacted, questions were asked during a semi-structured phone or face-to-face interview, and their responses were then recorded, transcribed and compiled as background information for development of the working draft of the *International Guidelines on Sexuality Education*.

A total of 11 in-depth interviews were conducted with a set of pre-determined questions using a semi-structured interview guide. The tool was developed to help document best practice with developing and implementing formal school-based sexuality education programmes and curricula. Interview questions on the semi-structured questionnaire were intentionally designed to be open-ended, and interviews with Key Informants were loosely structured to encourage free flow of information and ideas, and to maximise focus on their area of specialisation(s), while eliciting their feedback and response.

Eight of the interviews were completed by phone, and one by a face-to-face interview. Two of the informants preferred writing their responses instead of the phone interview, and two informants submitted written responses as supplemental information to their phone interviews. The phone interviews ranged in duration from one half hour to two and a half hours.

In addition, four more informal interviews were conducted with informants not on the Key Informant contact list because they were thought to have particular insight and/or experience that might be helpful. They included: Novia Condell, UNICEF Jamaica; Shirley Oliver-Miller, Independent ARSH Consultant; Bill Finger and Karah Fazekas of Family Health International (FHI). Although helpful, information provided was more limited in scope; thus, their responses were not transcribed and compiled with the other key informant interviews.



## Semi- structured interview questionnaire schedule

1. What has been your experience with developing and implementing sexuality education programmes in schools or in the formal education sector?
2. What has presented challenges?
3. What has been successful; what has worked?
4. What are the most important elements of quality sexuality education programmes?
5. What is the best way for Ministries of Education to work with schools to get them to promote and implement comprehensive sexuality education approaches?
6. How can we move schools and communities towards comprehensive sexuality education verses abstinence-only-until-marriage approaches?
7. What is (are) the best school-based sexuality education programme(s) you know about?
8. How should the programme be taught (what are the entry points) in schools (e.g., as a separate subject, along with a carrier subject, or integrated throughout the curriculum)?
9. What is the best process (or most promising practises) for ministries of education to undertake when developing and implementing a sexuality education programmes in schools?
10. What is important to include in an international guidelines document for ministers and policy makers that will help them implement quality programmes?

# Appendix IV

## Criteria for selection of evaluation studies

To be included in this review of sex, relationships and HIV/STI education programmes, each study had to meet the following criteria:

1. The evaluated programme had to:
  - (a) be a curriculum- and group-based sex, relationship, or STI/HIV education programme (as opposed to an intervention involving only spontaneous discussion, only one-on-one interaction, or only broad school, community, or media awareness activities).
  - (b) focus primarily on sexual behaviour (as opposed to covering a variety of risk behaviours such as drug use, alcohol use, and violence in addition to sexual behaviour).
  - (c) focus on adolescents up through age 24 outside of the US or up through age 18 in the US
  - (d) be implemented anywhere in the world.
2. The research methods had to:
  - (a) include a reasonably strong experimental or quasi-experimental design with well-matched intervention and comparison groups and both pretest and post-test data collection.
  - (b) have a sample size of at least 100.
  - (c) measure programme impact on one or more of the following sexual behaviours: initiation of sex, frequency of sex, number of sexual partners, use of condoms, use of contraception more generally, composite measures of sexual risk (e.g., frequency of unprotected sex), STI rates, pregnancy rates, and birth rates.
  - (d) measure impact on those behaviours that can change quickly (i.e., frequency of sex, number of sexual partners, use of condoms, use of contraception, or sexual risk taking) for at least 3 months or measure impact on those behaviours or outcomes that change less

quickly (i.e., initiation of sex, pregnancy rates, or STI rates) for at least 6 months.

3. The study had to be completed or published in 1990 or thereafter. In an effort to be as inclusive as possible, the criteria did not require that studies had been published in peer-reviewed journals.

## Review methods

In order to identify and retrieve as many of the studies throughout the entire world as possible, several tasks were completed, several of them on an ongoing basis over two to three years. More specifically, we:

1. Reviewed multiple computerised databases for studies meeting the criteria (i.e., PubMed, PsychInfo, Popline, Sociological Abstracts, Psychological Abstracts, Bireme, Dissertation Abstracts, ERIC, CHID, and Biologic Abstracts).
2. Reviewed the results of previous ETR searches for studies and identified those studies meeting the criteria specified above.
3. Reviewed the studies already summarised in previous reviews completed by others.
4. Contacted 32 researchers who have conducted research in this field asked them to review all the studies previously found and to suggest and provide any new studies.
5. Attended professional meetings, scanned abstracts, spoke with authors, and obtained studies whenever possible.
6. Scanned each issue of 12 journals in which relevant studies might appear.

This comprehensive combination of methods identified 109 studies meeting the criteria above. These studies evaluated 85 programmes (some programmes had multiple articles). All of these were obtained, coded and summarised in Table 1 and the text above.

# Appendix V

## People contacted and key informant details

Name, Title and Affiliation	Country/Region	Area(s) of Expertise
Akinyele Dairo UNFPA	Sub-Saharan Africa	Implementation and technical support
Alan Flisher University of Cape Town	Southern Africa	Research
Alice Welbourn Global Coalition for Women on AIDS, UNESCO's Global Advisory Group	Sub-Saharan Africa	Advocacy and technical support
Ana Luisa Liguori Ford Foundation	Latin America	Funding and technical support
Anne Biddlecom The Alan Guttmacher Institute	Sub-Saharan Africa	Research
Antonia Biggs, Claire Brindis University of California, San Francisco	US and Latin America	Research
Arvin Bhana Human Sciences Research Council UNESCO's Global Advisory Group	Southern Africa	Research
Bill Finger, Karah Fazekas Family Health International	Global	Technical support
Bruce Dick, Jane Ferguson WHO	Global	Coordination, research & technical support
Christopher Graham Jamaica Ministry of Education	Jamaica and the Caribbean	Implementation and advocacy
Cynthia Lloyd Population Council USA	Sub-Saharan Africa	Operations research
Daniel Wight Medical Research Council UK	UK, Caribbean and sub-Saharan Africa	Research
David Plummer University of the West Indies UNESCO Chair in Education	Southern Africa and the Caribbean	Research
Doug Webb UNICEF	Sub-Saharan Africa	Coordination and technical support
Eleanor Matika-Tyndale University of Windsor	Canada and Eastern Africa	Research
Esther Corona Mexican Association for Sex Education and World Association for Sexual Health	Mexico and Latin America	Implementation and advocacy
Frances Cowan University College London	Southern Africa	Research

Name, Title and Affiliation	Country/Region	Area(s) of Expertise
George Patton The Royal Children's Hospital Melbourne, Centre for Adolescent Health	Australia	Research
Harriet Birungi Population Council Kenya	Eastern Africa	Operations research
Helen Mondoh Professor of Education, Egerton University	Kenya	Implementation and research
Herman Schaalma University of Maastricht	The Netherlands	Research
Isolde Birdthistle, James Hargreaves, David Ross London School of Hygiene & Tropical Medicine	Sub-Saharan Africa	Research
Jenny Renju Liverpool School of Tropical Medicine, National Institute for Medical Research Tanzania	United Republic of Tanzania	Implementation and advocacy
Joanne Leerlooijer, Jo Reinders World Population Fund (WPF)	India, Indonesia, Kenya, The Netherlands, Thailand, Uganda, Viet Nam	Implementation and technical support
John Jemmott University of Pennsylvania	US and South Africa	Research
Juan Diaz Population Council Brazil	Brazil and Latin America	Operations research
Lisa Mueller Programme for Appropriate Technology in Health (PATH)	Botswana, China, Ghana and United Republic of Tanzania	Implementation and technical support
Lynne Sergeant UNESCO HIV and AIDS Education Clearinghouse	Global	Technical support
Maria Bakaroudis Independent Consultant	Malawi	Research and technical support
Mary Crewe University of Pretoria	Sub-Saharan Africa	Research
Nanette Ecker SIECUS	Global	Technical support
Nike Esiet Executive Director, Action Health, Inc. (AHI)	Nigeria	Implementation and advocacy
Peter Aggleton, Vicki Strange Institute of Education, London UNESCO's Global Advisory Group	UK and global	Research
Rachel Jewkes Medical Research Council, South Africa	Southern Africa	Research
Sanja Cesar Programme Manager, Centre for Education, Counselling and Research	Croatia	Implementation and advocacy
Susan Philliber Columbia University	North America	Research
Tajudeen Oyewale UNICEF	Nigeria	Research and implementation

# Appendix VI

## Bibliography of useful resources

This bibliography of *how-to* materials was developed to accompany the *International Guidelines on Sexuality Education*. It is composed of existing, high quality sexuality education curricula, curriculum guides and teacher training manuals from around the world. The bibliography is intended to serve as a practical tool for curriculum developers, programme planners, school principals and teachers. The resources were selected based on criteria established at the expert technical consultation in February 2009:

- Contributes towards comprehensive sexuality education curricula, curriculum guides or teachers training manuals
- Evaluated or recommended by experts
- Recently published (1998-2009) with accurate, up-to-date information reflecting latest “state-of-the-art” knowledge
- Targeted to learners or educators, particularly at the primary and secondary school level, but also including the tertiary level
- Available in English, French, Spanish or Portuguese

Updated versions of this practical resource list can be found on the UNESCO HIV and AIDS Education Clearinghouse website <http://hivaidsclearinghouse.unesco.org/>

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SIECUS' SexEd Library <http://www.sexedlibrary.org>

Speakeasy for Parents <http://www.c4urself.org.uk/speakeasy.php>

TARSHI website and helpline <http://www.tarshi.net/>

# Appendix VII:

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# Appendix VIII

## Reference Material for the *International Guidelines*

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